April 1981

FORUM

Health Care Financing Administration

How Some States Weather High Cost of Hospital Care

What's Fair? Ethical Issues in Financing Health Care

HCFA

The *Health Care Financing Administration* (HCFA) was established to combine health financing and quality assurance programs under a single agency. HCFA is responsible for the Medicare program, federal participation in the Medicaid program, the Professional Standards Review program, and a variety of other health care quality assurance programs.

The mission of the Health Care Financing Administration is to promote the timely delivery of appropriate, quality health care to its beneficiaries—approximately 47 million of the nation's aged, disabled and poor, The agency must also ensure that program beneficiaries are aware of the services for which they are eligble, that those services are accessible and of high quality, and that agency policies and actions promote efficiency and quality within the total health care delivery system.

Forum

Forum, the official magazine of HCFA, is published to inform a wide audience on all aspects of health care financing and the activities and programs of the agency. Among its readers are health care administrators, planners, and other professionals; state health and health financing agencies; and major public and private corporations institutions, and associations that finance health care for their members or employees.

Forum provides information on actions and policies that promote efficiency and quality within the total health care system, promoting discussion and debate of the complex issues and problems relating to health care. By soliciting views from outside HCFA and the Department, *Forum* contributes to a constructive relationship and dialogue among the agency and health care providers, third-party payers, and other segments of its readership.

Editorial Comment

Can the states do it? Can they hold down inflationary increases in costs of health care, yet maintain the quality of that care? Read in this issue of *Forum* about the measures, both mandatory and voluntary, undertaken by some *states to restrain hospital costs* without unduly burdening the institutions nor denying care to those who need it.

Cost containment measures are nothing new to institutions in the nation's largest centrally directed health care system. *Veteran's Administration hospitals* and other care facilities make the system's size and flexibility work toward economy of care. Yet, as *Forum* reports, quality of care and patient satisfaction remain high.

Not all health care concerns are pragmatic. Two authors in the current *Forum* offer theories and supporting facts on ethical and spiritual aspects, respectively, of the subject. Are health services in this country allocated fairly and who gets access to them? Who is entitled to a heart transplant, if needed, and is age a valid factor? These are some of the *ethical issues in health care* discussed, along with their effects on the financing of services.

Another article, while detailing the dollars-and-cents facts of financing services for a growing number of the disabled in the United States, also reminds readers of the especially difficult circumstances of living many recipients of Disability Insurance face, and the critical role of Medicaid and Medicare in enabling them to live and sometimes work productively.

And finally—*changes to Medicare and Medicaid?* Yes, but these changes were made in 1980, by the last Congress. *Forum* sums up the modifications to law, some of major importance to the programs. Most take effect this year.

Virginia T. Douglas
Editor

Editor's Note: Forum did not publish a February issue this year, but readers will receive the full number of issues for which they initially subscribed.

Volume 5, Number 1 April 1981

FORUM

Health Care Financing Administration

Articles

U.S. Department of Health and Human Services
Richard S. Schweiker, Secretary

Health Care Financing Administration
Carolyne K. Davis, Ph.D., Administrator
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2 Departments

Update

Dr. Carolyne K. Davis was sworn in as Administrator of HCFA by HHS Secretary Richard S. Schweiker in Washington, D.C., on March 2nd.

Carolyne K. Davis, Ph.D., university administrator and nurse, named as HCFA Administrator.

University administrator and nursing educator Carolyne K. Davis has been named to head the Health Care Financing Administration. She took up her new post March 2nd.

Since 1975, Dr. Davis was Associate Vice President for Academic Affairs of the University of Michigan, where she was also a professor in the Schools of Nursing and Education.

At Michigan, she coordinated the activities of the Schools of Public Health, Medicine, Dentistry, Nursing, and Pharmacy. Her work also involved supervising and administering 13 units with 500 employees and allocating over $6 million in general funds. Among the units were the Institutes of Gerontology and Mental Retardation and the Center for Human Growth and Development. She chaired the cost containment committee of the University Hospital and served on the executive committee of the Medical School's medical practice plan. From 1973 to 1975, she was Dean of the University's School of Nursing.

Prior to 1975, she spent a decade at the Syracuse University School of Nursing, where she held progressively more responsible positions, beginning as a lecturer in pediatric nursing and culminating as chairman of the baccalaureate program. Earlier in her nursing career, Dr. Davis was connected with Lankenau Hospital, Philadelphia, and the Mercer Hospital School of Nursing in Trenton, New Jersey.

Her Ph.D. in higher education administration and her M.S. in nursing education were earned at Syracuse University. She also holds a B.S. in nursing from John Hopkins University. Dr. Davis has written extensively on nursing practice, education, and costs.

Between 1978 and 1980, Dr. Davis chaired the Michigan Health Data Corporation, a consortium of top Michigan voluntary and government agencies concerned with health care. One of its tasks was collecting and interpreting data on bed utilization in Michigan hospitals and communicating this information to the hospitals for appropriate action.

Among her other recent professional activities are: consultation to HEW's Division of Nursing concerning regulations for the Nurse Training Act of 1975; cochairman of a panel of experts for an HEW-funded study by the Western Interstate Council for Higher Education on nursing and nursing education; cochairman of a consultant panel on analysis and planning for improved distribution of nursing personnel and services, 1976-77; consultation to the University of North Carolina on statewide health program needs, 1976-78; assistance on matters of nursing, health, and education to the University of Colorado, and Johns Hopkins, Cornell, and Michigan State Universities, all during 1977 and 1978; and service on the board and executive committee of the Michigan Heart Association.

Her work for the University of Michican involved Congressional liaison, and in 1980, she testified before Congress concerning proposed health manpower legislation.

Currently, Dr. Davis is a member of the American Nurses Association, the American Association of Higher Education, the American Council on Education, and the National League of Nursing. For the latter, she participated in a task force on cost analysis for nursing education programs. In 1978, she was named a Fellow of the American Academy of Nursing. She is a member of the board of trustees of Johns Hopkins University.

Dr. Davis was born in Penn Yan, New York, and is married to Ott Howard Davis, Jr. They have a son, Richard Ott Davis.

Proposed certification of Medigap policies would help Medicare beneficiaries

Regulations that would allow for the certification of Medicare supplemental health insurance policies (so-called "Medigap" policies) voluntarily submitted for review were proposed recently by the Department of Health and Human Services to implement legislation signed by the President last June 9.

The program is designed to help Medicare beneficiaries identify policies that provide adequate, fairly priced protection against many health care expenses not paid for by Medicare.

About 15 million Medicare beneficiaries (or two-thirds of the Nation's elderly) spent $4 billion in 1978 for approximately 19 million policies to supplement Medicare. These Medigap policies pay approximately 5 percent of the health costs of the aged.

The legislation establishes a Supplemental Health Insurance Panel, composed of the Secretary of HHS and four State Commissioners of Insurance, to evaluate state regulatory programs concerning Medigap policies and determine whether they

assure that the policies meet certain minimum standards. In states the panel determines do not comply with federal standards, the certification program will become effective July 1, 1982.

Half of hospital stays, 30 percent of surgery unneeded, say nurses polled

Nearly half of the nation's nurses say that 30 percent of surgical operations and 50 percent of hospital stays are medically unnecessary, according to a recent nationwide poll conducted by *RN Magazine*.

Of the 12,500 nurses polled, 83 percent favor advising patients of less expensive therapeutic alternatives, if available. Nurses, as independent health care professionals, believe themselves to be well enough informed that they need not rely totally on the physician's word, according to the journal. *RN Magazine* is published by the Medical Economics Company of Ordell, New Jersey, for registered nurses and nursing students. Said the RN report:

"Physicians can say goodbye to the unquestioned support that decades of handmaiden nursing has led them to expect."

HCFA campaign continues for 2nd opinion on surgery

A nationwide campaign to encourage the nation's adults to seek second medical opinions in cases involving non-emergency surgery is continuing under the aegis of the Health Care Financing Administration, DHHS.

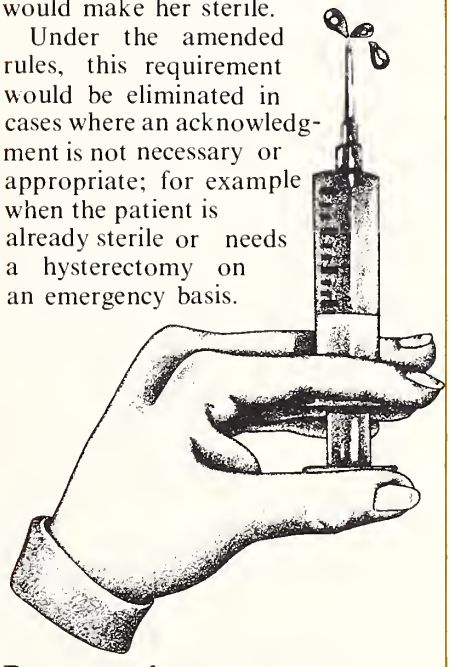
Bulk quantities of a brochure on the program can be obtained free from: Surgery, HHS, Washington, D.C. 20201. Referrals to physicians who will render second opinions are made via a toll-free telephone number: 800-638-6833 (or, in Maryland, 800-492-6603).

Change in acknowledgment for hysterectomies proposed

A proposal to amend the rules governing federal funding for hysterectomies was recently announced by the Department of Health and Human Services.

Current regulations for Medicaid and Public Health Service programs permit funding for hysterectomies only if the patient or her representative signs an acknowledgment that she was informed that the operation would make her sterile.

Under the amended rules, this requirement would be eliminated in cases where an acknowledgment is not necessary or appropriate; for example when the patient is already sterile or needs a hysterectomy on an emergency basis.



Program changes concern pneumonia vaccines and disposal of assets

Two provisions of Public Law 96-611, signed by the President last December, affect Medicare and Medicaid beneficiaries: sections concerning pneumonia vaccinations and determination of assets of Medicaid applicants.

Effective July 1, Medicare will cover pneumococcal vaccine and its administration. The law provides for payment at 100 percent of reasonable charge, with no deductible or coinsurance.

(Note: the Administration is asking Congress to repeal this benefit expansion because of the need for budgetary restraint.)

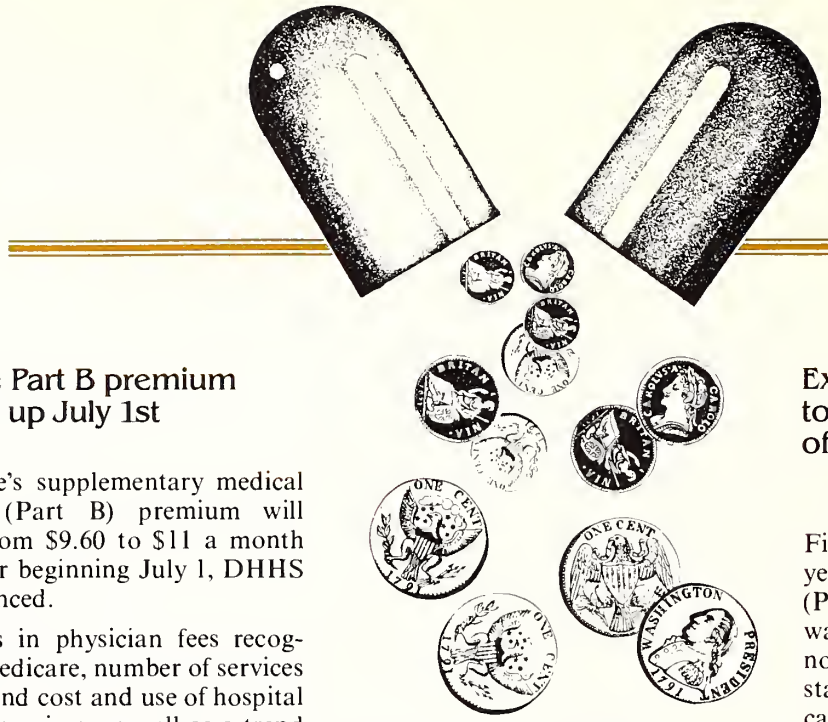
Another section of the law provides that individuals otherwise eligible for Medicaid who dispose of resources for less than fair market value may be denied medical assistance. A state that chooses to establish such a restriction must specify a procedure no more restrictive than that spelled out for the Supplemental Security Income Program. (For SSI applicants, such resources must be included when the applicant's resources are determined, and the value of the transferred asset, less compensation received for it, will be considered available for the individual's support during the two years following transfer of the asset.) For Medicaid applicants, however, if the uncompensated value of the resource exceeds $12,000, the ineligibility period may exceed two years.

How is income from spouse of Medicaid patient counted? Supreme Court to rule

The Supreme Court has agreed to decide whether states may reduce Medicaid payments by estimating the "available" income of an institutionalized patient's spouse.

Lower courts have ruled that, in certain states, the payments may be reduced only by the amount of spouse income that is actually available to help pay for the patient's care, not by a state estimate of that income.

The Department of Health and Human Services asked the Supreme Court to resolve the question after the Gray Panthers, a citizen group representing the elderly, sued the Department for a change in its rules and won. The ruling could substantially affect both the number of eligible Medicaid applicants and the amount of their benefits.



Medicare Part B premium set to go up July 1st

Medicare's supplementary medical insurance (Part B) premium will increase from $9.60 to $11 a month for the year beginning July 1, DHHS has announced.

Increases in physician fees recognized by Medicare, number of services rendered, and cost and use of hospital outpatient services, as well as a trend toward more expensive services, are the major factors in the 14.3 percent rise.

Part B, which complements the basic hospital insurance part of Medicare by helping to pay physicians' bills and other medical expenses in and out of the hospital, will have an enrollment of about 28.3 million persons in fiscal year 1982. This includes 2.8 million disabled persons under age 65 and 25.5 million persons age 65 or older.

Under law, the Secretary of Health and Human Services must review the cost of the Part B program each December. The premium rate, together with the federal contribution, must cover all expenditures required during the upcoming fiscal year.

Benefit costs under Part B are expected to increase from about $12.4 billion in FY 1981 to $15 billion in FY 1982. The law does not, however, permit the percentage increase in the premium to exceed that of social security cash benefits (which, in June 1980, increased by 14.3 percent). Thus, the medical insurance premium may increase by no more than 14.3 percent, yielding the new premium of $11.

Were the annual percentage increases not limited to the increase in social security benefits, the monthly premium for next year would be set at $22.60 to cover costs.

Drug programs saved millions, says GAO, but it could have been billions

Programs to cut down on prescription drug costs paid by Medicare and Medicaid have saved millions of dollars, the General Accounting Office says, but further savings could be obtained if the programs were bolstered. Medicare and Medicaid pay more than $1.75 billion a year for prescription drugs.

The figures reported to Congress came from a two-year study of the effectiveness of drug cost programs in California, Florida, New Jersey, Georgia, and Texas, according to Acting Comptroller General Milton Socolar.

One program, called Maximum Allowable Costs (MAC), saved $1.4 million by setting a top limit on the amount that could be reimbursed for drugs available from more than one source; the other set reimbursement limits based on the pharmacists' estimated acquisition costs of the drugs, seeking to move states away from using the "average wholesale prices" for setting limits. The Health Care Financing Administration, which administers the drug programs, believes that average wholesale prices (which include a mark-up) are 15 to 18 percent higher than prices at which pharmacists can buy the drugs directly from the manufacturer.

Exchange of personnel to PEP up administration of health care programs

First selections for the Health Care Financing Administration's new, one-year professional exchange program (PEP), were announced recently. PEP was established to help federal and non-federal institutions better understand each other's approach to health care delivery.

Beginning this spring, employees from non-federal agencies will work at HCFA in Baltimore and Washington, while HCFA employees will work at outside agencies for a year. Employees then will return to their home organizations.

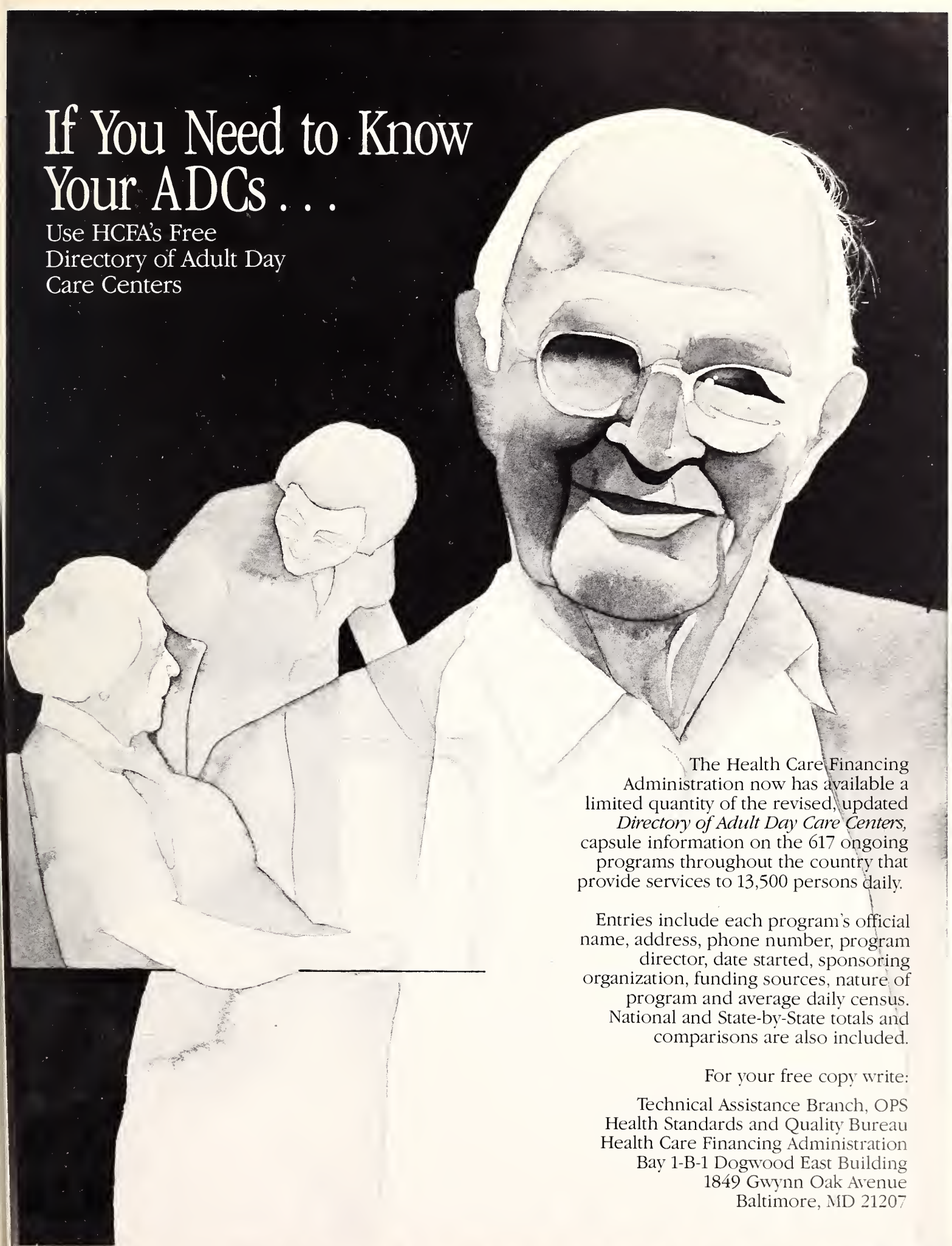
Three non-HCFA employees were named: Michael J. Clifford, Georgia Health Planning and Development Agency; Robert L. Lovato, New Mexico Health and Environment Department; and Ethel J. Parker, District of Columbia Department of Human Services. All were recommended by a panel of private-sector representatives.

Six HCFA employees will be selected to fill positions with the Association of University Programs in Health Administration in Washington, D.C.; the National Association of Counties in Washington, D.C.; the Health Services Cost Review Commission in Baltimore; the New Mexico Health and Environment Division; the Oregon State Health Division; and the Maryland Health Planning and Development Agency.

PEP is conducted under the provisions of the Intergovernmental Personnel Act, which allows participation of state and local governments, educational institutions and nonprofit organizations that provide public management services to the Federal Government.

If You Need to Know Your ADCs . . .

Use HCFA's Free Directory of Adult Day Care Centers



The Health Care Financing Administration now has available a limited quantity of the revised, updated *Directory of Adult Day Care Centers,* capsule information on the 617 ongoing programs throughout the country that provide services to 13,500 persons daily.

Entries include each program's official name, address, phone number, program director, date started, sponsoring organization, funding sources, nature of program and average daily census. National and State-by-State totals and comparisons are also included.

For your free copy write:

Technical Assistance Branch, OPS
Health Standards and Quality Bureau
Health Care Financing Administration
Bay 1-B-1 Dogwood East Building
1849 Gwynn Oak Avenue
Baltimore, MD 21207

Setting an Example: VA Hospitals Restrain Costs

Economies of scale help; so do more ambulatory care, shorter inpatient stays

by Susan Matson

THROUGH AN EMPHASIS ON ambulatory care and shortened in-hospital stays, the country's largest centrally directed health care system—that of the Veterans Administration—has held its increase in costs of care to just 60 percent of the national average.

Although the average VA patient is older than patients generally and might be expected to use more care, the VA reported an increase in operating costs of just 7.5 percent in 1979, while U.S. health care costs grew about 12 percent. The VA sets an example for other budget-watching health administrators.

The Veterans Administration health care system encompasses 172 medical centers (a VA medical center consists of a hospital, outpatient clinic, and usually facilities for medical education and research), and 54 satellite or independent clinics. It also operates 16 domiciliaries and 92 nursing homes. The quality of care at VA hospitals is monitored by 43 professional groups, and all the hospitals are accredited by the Joint Commission on the Accreditation of Hospitals (JCAH). In 1979, the VA treated about 1.3 million hospital patients, while outpatient visits amounted to over 17 million.

VA patients are of course almost exclusively veterans—individuals retired or separated from active military service. (A relatively few active duty service personnel and members of veterans' families are treated, under special circumstances.) First priority is given veterans for service-connected disabilities; then veterans with such disabilities who are seeking care for some other medical problem; and finally all other veterans, on a space-available basis, may receive needed hospital care if they cannot afford it elsewhere. (Veterans in the last category who are 65 or older do not have to prove financial need.)

Vast as it is, the VA health care umbrella is just a part of a system that eventually touches most American males. We now have over 30 million veterans—45 percent of U.S. men. That proportion will rise to just over half in 1990 and to 52.5 percent by the year 2000. Two-thirds of living veterans have received at least one veteran's benefit since leaving the armed forces, a 1978 survey indicated.

The VA sets an example for other budget-watching health administrators

In demographic profile, veterans largely echo the civilian population (see box)—except for being older. Given this, it might be expected that a sizable percentage of VA clients would be in nursing home or extended care facilities. Not so. Of the 2.4 million applications for care processed by the VA in 1979, only .2 percent were for nursing home and domiciliary care, while 37.8 percent were for hospital care and 46.1 percent were for ambulatory (outpatient) care. (The rest either did not need care or were ineligible for the VA benefit they were seeking).

(Heart disease ranks as the VA system's number one broad diagnosis area, followed by psychotropic disease—including alcoholism, drug abuse, and psychiatric disorders. As a single diagnosis, alcoholism is the largest reported concern.)

Outpatient care stressed

Because many of their clients have life-long eligibility for care, the VA is more atuned to long-term recovery than some private hospitals might be.

In response to the need for long-range care, the VA has expanded types of care available, many at the lower end of the scale of intensity. The system is currently examining hospital-based home care, which utilizes the multidisciplinary health care team—what may be called "the 1980s version of the house call." Teams include practitioners ranging from medical to rehabilitation specialists and social workers.

While partly a reflection of a national trend, the outpatient phenomenon at the VA also stems from a conscious policy decision implemented in the mid-1970s. Nowhere is it evident than in psychiatric care.

Pioneering in psychotropic drugs

"The mental health field was encouraging ambulatory care long before medicine and surgery did," explains Dr. Robert Custer of the VA's mental health division. "Our outpatient program have doubled out the past ten years, and we know that the patients are a lot happier and better off."

The division's outpatient arm is represented by VA mental hygiene clinics, which now total 136 units. Day treatment centers number 55 and hospital facilities, 40.

Susan Matson is a Washington, D.C., writer and researcher. She has written on the End State Renal Disease program and on alcohol and drug abuse problems.

Directed and encouraged from the VA's central office in Washington, ambulatory care has considerable grassroots support at VA facilities. "Our increased use of an open-door policy means a change in attitude for both staff and patients," says Dr. Custer. "More responsibility means enhanced mental health."

The VA supplements its dependence on ambulatory care with a stepped-up training program in living skills for patients and the judicious use of tranquilizers and other psychotropic drugs. VA medical researchers are credited with development of many of the psychotropic drugs that now form the industry standard for treating psychiatric disorders.

To contain length of stay, VA hospitals use screening process.

Usage of ambulatory care may have peaked, some VA administrators believe (the 17,263,000 outpatient visits in 1979 represent a slight drop from 17,416,000 in 1978). "There is a finite limit, but we are well on our way," says Dr. John Castellot of the intenal medicine staff. "The mandatory inpatient workload has to be our first priority."

Shorter stays, greater savings

Emphasis on outpatient treatment goes hand-in-hand with making sure that inpatient care, when needed, is as short and intensive as possible. In general, length of stay is still somewhat longer in VA hospitals than in community hospitals, probably because of the difference in:

(1) *Case-mix* (the VA sees relatively fewer acute, medical/surgical patients and more patients with long-term conditions, as well as older patients requiring extended care), *and*

(2) *Conditions of discharge* (patients may be delayed in leaving the hospital while arrangements for post-discharge placement are made, in cases of long-standing medical problems).

But over the past decade, the VA's average length of hospital stay dropped sharply: from 20.8 days in 1970 to 15.3 in 1980. (This is for the group representing the vast majority of patients—97 percent—who stay fewer than 100 days.)

One reason may be the system's length of stay screening process, now three years old. Employing a comprehensive series of booklets for field use, the process was tailored to each of seven provider types and established specific standards for 19 disease categories. The system was originally mandatory.

"Hospitals were supposed to screen their lengths of stay for each of the categories to see if they were generally within the norm," explains VA Dr. Carl Tribble. "But some hospitals went too far in taking the norm literally, as an ultimate mandate."

Screening is no longer mandatory, but the majority of VA hospitals still use it on a voluntary basis, both to contain length of stay and to monitor clinicians' behavior. The example has been set, and Tribble is optimistic about the self-monitoring process.

At the same time, he acknowledges, any such cost containment program requires flexibility. "If you put a patient out two days too early, he may come back again with the kind of problems that really call for intensive care."

Obviously, length of treatment is often discretionary. Prolonged illnesses, such as cancer, that permit the clinician the most discretion in the number of visits may be worth further examination in terms of cost containment. The VA's systematic internal review (SIR) process, under the auspices of the agency's Health Services Review Organization, furthers this idea by requiring that each facility examine length of stay along with other treatment considerations. Outside review is provided by he systematic external review program (SERP), which teams multidisciplinary professionals from several hospitals to review SIR systems. SERP, which sets higher standards than does JCAH, is coordinated by team leaders from the VA's central office.

Shorter lengths of stay mean increased turnover, which means greater cost effectiveness. While the number of admissions today has doubled since 1969 (159,771 versus 87,150), the VA operates successfully with half the number of beds (25,375 versus 50,129).

Since 1970, although the VA's *per diem* costs have more than tripled, its cost per inpatient treated has been much less inflationary, about 180 percent, as indicated in Figure 1.

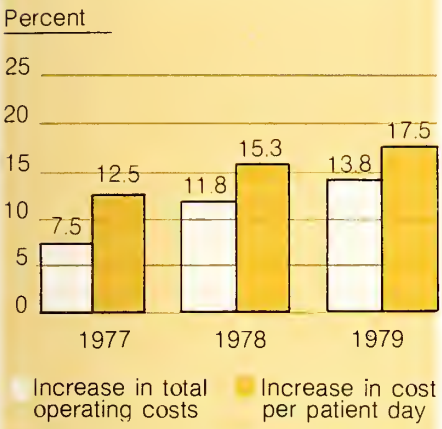
Figure 1. Cost Effectiveness of Increased Turnover in VA Hospitals

	Average Cost Per Inpatient Day		Cost Per Inpatient Treated	
Fiscal Year	Amount	Index (1970 = 100)	Amount	Index (1970 = 100)
1970	$ 38.42	100	$ 1,524	100
1971	43.41	113	1,626	107
1972	52.61	137	1,851	121
1973	57.92	151	1,769	116
1974	65.08	169	1,855	122
1975	75.71	197	1,984	130
1976	87.86	229	2,135	140
1977	103.27	269	2,346	154
1978	119.10	310	2,583	169
1979	133.82	348	2,772	182

Source: Veterans Administration. *Annual Report, 1979.*

Much of the progress has taken place in the last three years. With national health care cost rising at a rate of about 12 percent a year, the VA health care system showed an operating cost increase of just 7.5 percent in 1979, an improvement over 1977 (see Figure 2). Costs per patient day also represent a substantial improvement from 1977.

Figure 2.
Yearly Cost Increases within VA Health Care System



Source: Veterans Administration. *Annual Reports, 1977, 1978, 1979.*

When expenses per acute-care episode are compared, VA hospital figures for fiscal year 1978 show their costs to be 93.4 percent of AHA data for community hospitals ($2,450 per episode vs $2,622). (The VA adjusted its data to be as comparable as possible, dropping out some research and medical education costs not generally found in community hospitals.)

Cleaning up on laundry bills

While ambulatory care and inpatient turnover are the major contributors to the VA's inflationary scaledown, several innovative projects have also contributed to cost savings.

Silver recovered from scrap x-ray film returns millions of dollars.

For example, laundry bills were a sizeable component of inpatient costs, until a recent program found ways for regional VA hospitals to centralize their cleaning services. The grouping of forces—together with a campaign encouraging the use of chemical cleaners effective in cold water—in 1979 saved the VA $3 million over the previous year.

One cost containment oddity is the VA's silver recovery program, begun in 1963. Throughout VA medical centers, silver is collected from x-ray processing solutions and scrap medical x-ray film. During fiscal year 1980, over $13.6 million was received from the sale of the bullion and scrap film.

Profile of Veterans

As a whole, veterans do not suffer more unemployment than their non-veteran counterparts nor are they necessarily poorer. In 1978, the last year for which statistics are available, 84.5 percent of male veterans in the civilian, non-institutional population worked at some time, compared with only 80.6 percent of non-veteran males.

The median 1978 income of U.S. families headed by male war veterans was $21,760 compared with $17,350 for families headed by nonveterans. (However, total income declines rapidly for families whose veteran head reaches the age of retirement; this means a median income of $13,960 when that head is between 65 and 69, and $10,710 for those aged 70 or over.)

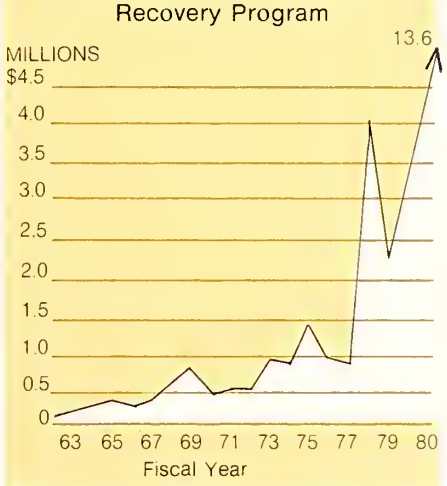
Women now constitute only 2 percent of the veteran population, but their number are increasing.

Since the Veterans Administration automatically qualifies all ex-military over the age of 65 for veterans' benefits, one would expect an older health care population. The statistics bear this out: almost 13 percent of all VA applications for health care represent those 65 and over. Further, the average ex-military man in civilian life (47.5 years old in 1979) will be 52.5 years old in 2000.

Even more significant in terms of health care will be the increasing number of veterans 65 and over resulting from the population "bulge" of World War II vets. In the 65-plus age bracket, it is estimated the numbers will jump from 2.96 million in 1980 to 7.188 million in 1990 (a projection based on 1979 military requirements) before tapering off due to natural attrition.

These proceeds are returned to the medical centers. The rising income from this source over 17 years (see Figure 3) reflects intensified VA initiatives as well as the recet boom in silver market prices. For example, receipts spiked in 1978 when the VA sold silver it had withheld from the market in 1977 for administrative reasons; dropped to a "normal" increase in 1979; then spiked again in 1980 because of increased prices of silver.

Figure 3.
Income from VA Silver Recovery Program



Source: Veteran's Administration. *Annual Report, 1979.*

Centrally procured supplies offer another opportunity—which the VA has seized—for savings. This area of achievement is perhaps most directly related to the large size of the health care system. The annual cost of furnishing supplies, equipment, utilities, and services to VA facilities in fiscal year 1979 was $1.1 billion (another $37 million was spent to supply other government agencies participating in the centralized supply system). The VA's revolving fund for supplies, without fiscal year limitation, covers the cost of warehouse inventories at depots and medical centers.

Most supplies are procured centrally at volume discounts, which accounts for an annual savings of over $100 million or about 6 percent of the total. It is reasonable to assume that facilities in other centrally operated health care systems could achieve similar savings by pooling resources and operations.

VA blueprints multilevel care

To offset the rising salaries of professional staff, the VA has increased its use of paraprofessionals. Three-fourths of medical and surgical expenses are personnel-related, according to Lawrence Bettes of the VA's medical resource management office, who also pointed out that VA salary levels are fixed by statute. In some instances, the new stress on ambulatory services has required an extended staff, as in hospital-based home care (mentioned earlier).

This could mean higher costs. But many VA facilities have determined that, by employing two-and-one-half nurses for the cost of one experienced physician, they can expand services without increasing costs. This is especially true in the case of triage, in which routine activities, such as histories and physicals, can be satisfactorily conducted by non-physicians.

A multidisciplinary team approach was a primary consideration in phasing many VA psychiatric patients from inpatient to ambulatory care. The other health professionals gave physicians considerable help in presenting a united front about the patient's needs, according to VA psychiatrist Dr. Robert Custer.

VA officials are still developing blueprints for a system of multilevel care that holds promise for both cost containment and resource tracking. The objective is to match each patient's variable medical needs with different levels of health care resources. Thus, patients with severe, but dissimilar diseases that require several physician visits per day might be placed in the same ward to consolidate staff efforts.

A financial management subsystem will help determine: (1) average *per diem* costs by level of care; (2) costs per episode of care; (3) the efficiency of mechanisms for resource monitoring and management; (4) the viability of a prospective budgeting system based on patient needs and staff workload.

After two years of development, multilevel care was tested in 1978 in ten VA medical centers; it is still under scrutiny by the VA's national program planning office.

The VA has other cost control plans and procedures, including a current cost comparison study of inpatient services scheduled for completion this spring. But of equal concern to health care providers is the quality of care—as seen by both VA staff and patients.

Good care, satisfied patients

To ensure quality of care is the special work of the VA's evaluation and analysis branch. As previously discussed, the SIR and SERP review procedures work to ensure adherence to internal and external standards of medical care. The VA has launched two long-term projects to refine the external review system. The first develops objective, uniform criteria for outside surveyors examining a particular service, while the second, a quality assurance information system, will use SIR and SERP information to improve the validity, reliability, and usefulness of evaluation data within the VA.

VA staff-to-patient ratio is at an all-time high.

Quality of care assurance is managed by the VA's chief medical director, working through divisional chiefs who are in continuing contact with medical regional and district directors. The most recent data show fewer than four malpractice claims made by patients per 100 VA physicians, considerably below the private sector figures of approximately six claims *closed* per 100 physicians. This comes at a time when the VA's staff-to-patient ratio is at an all-time high.

Patient satisfaction is documented in the VA's third biennial patient survey, distributed and analyzed in fiscal year 1979. More than 19,000 hospitalized patients and 28,000 clinic patients participated as a representative sample. For the system as a whole, satisfaction is high. Most aspects of satisfaction received positive ratings in the 80s (on a scale of 100), with some in the 90s.

In fact, comparing findings with data from studies of the general population, VA hospitalized patients appear to be considerably more satisfied with their nursing care and food than are patients receiving care from other sources and somewhat more satisfied with the care provided by their physicians.

Comparisons show that VA outpatients are somewhat more satisfied with the time spent waiting for treatment and the courtesy of employees than are those in the non-VA sector. There were no areas in which VA patients were significantly less satisfied than those receiving care from other sources.

Centralization, flexibility cited

While ensuring premium quality and responsiveness in the health care it provides, the Veteran's Administration has made cost containment a high priority. The VA's chief medical director, Donald L. Custiss, M.D., believes that the VA's cost containment efforts are worthy of attention and attributes its achievements to improved technology, the fact that the system is the nation's largest and most comprehensive, and the VA's capability of procuring and distributing supplies and equipment on a national basis.

"An integrated and centrally managed system," he says, "obviously provides opportunities for economies of scale and for sharing. We have taken and will take advantage of such opportunities."

At the same time, however, he pointed out that management flexibility at each individual health care facility is the key to an effective system in this as in other matters. In other words, "Centralized management doesn't mean micromanagement," he says. "If that happens, the balance for successful operations tilts, and something inevitably falls."

In any case, he expresses certainty that those VA and other systems in our pluralistic health care universe can learn from one another without falling into the trap of attempting to mechanically apply set patterns that may not fit a given situation.

Clearly the VA is a giant that bears watching—for its pleasant surprises in cost containment. ■

CHANGES MADE
IN MEDICARE, MEDICAID, PSRO PROGRAMS

Budget Reconciliation Act
cuts spending by $1.1 billion

SOME MAJOR CHANGES WERE MADE IN THE Medicare, Medicaid, and PSRO programs when the Congress passed the Omnibus Budget Reconciliation Act of 1980 and the President signed it into law on December 5th (Public Law 96-499).*

The Act represents the most significant legislation enacted since 1972 affecting HCFA programs, containing over 50 provisions relating to them. The purpose of the Act was to narrow the gap between limits that budget committees had earlier set on total federal spending and the amount Congress actually authorized last year. As a result $1.1 billion was pared from Medicare and Medicaid spending.

Of special importance are a section that provides coverage for unlimited home health care visits under Medicare (by eliminating both the Part A requirement of three days' prior hospitalization and the Part B $60 deductible prerequisite), and another change that allows proprietary home-health agencies in all states to participate in Medicare (previously, participation was limited to states that licensed them).

HCFA has notified Medicare carriers and intermediaries, Medicaid state agencies, and social security district offices of the provisions of the law, and has prepared detailed work plans and schedules for implementing each provision.

Relevant sections of the law are summarized below under the categories *improvements in benefits, reimbursement reform, administrative improvements, Professional Standards Review Organizations, and long-term care facilities.* (The effective year is 1981, unless otherwise stated.)

Improvements in benefits

HOME HEALTH SERVICES Provides for coverage under Medicare of unlimited home health visits; eliminates the 3-day prior-hospitalization requirement for home health services under part A;* eliminates the $60 deductible for home health services under part B; includes occupational therapy as qualifying criteria for home health benefits;* and permits proprietary home health agencies to participate in states not having licensure laws. Effective July 1. (Section 930)

PREADMISSION DIAGNOSTIC TESTING Provides full reimbursement under Medicare for diagnostic services provided in a hospital's outpatient department and, to the extent practical (as determined by the Secretary), in a physician's office within 7 days prior to the patient's admission as an impatient. Effective on enactment. (Section 932)

OUTPATIENT REHABILITATION FACILITIES Recognizes comprehensive outpatient rehabilitation facilities as Medicare "providers"; authorizes Medicare reimbursement for rehabilitation services provided in a certified outpatient rehabilitation facility. Effective with accounting periods beginning July 1. (Section 933)*

OUTPATIENT PHYSICAL THERAPY Increases annual limit from $100 to $500 for outpatient physical therapy services under Medicare. Effective with expenses beginning calendar year 1982. (Section 935)*

DENTAL SERVICES Expands coverage under Medicare to include services provided by dentists which would be covered under current law when provided by a physician. Also covers hospital stays where they are warranted by the severity of the noncovered dental procedure. Effective July 1. (Section 936).*

OPTOMETRIST SERVICES Provides Medicare coverage of optometrists for treatment of aphakia. Requires Secretary to submit legislative recommendations to Congress by January 1, 1982, for coverage of optometric services in connection with cataracts and other services authorized under licensure. Effective July 1. (Section 937)

* Note: this spring, as a result of the need for budgetary restraint, the Administration is asking Congress to repeal or modify certain low-priority provisions of the Budget Reconciliation Act. These provisions are marked with an asterisk.

ANTIGENS Covers antigens under Medicare prepared by one physician and forwarded to another for administering to the patient. Effective January 1. (Section 938)

PLANTAR WARTS Eliminates Medicare coverage exclusion of planter warts. Effective July 1. (Section 939)

ENROLLMENT IN PART B OF MEDICARE Permits Medicare beneficiaries to enroll in part B at any time, with entitlement beginning on the third calendar month following the month of enrollment. Also provides for unlimited reenrollment in part B and in part A for those who purchase that protection.*Effective April 1. (Section 945)

BUY-IN AGREEMENTS Provides that states which currently do not have part B buy-in agreements may enter into such agreements and permits states that now have buy-in agreements which cover only cash assistance recipients to cover other Medicaid eligibles. Effective during calendar year 1981 only. (Section 945)*

PAYMENT FOR SERVICES FURNISHED TO DECEASED BENEFICIARIES Provides that person with legal obligation to pay physician bill for deceased beneficiary may be reimbursed by Medicare, even for unassigned claims, prior to payment of the bill. The current system requires payment of the physician's bill before Medicare will reimburse for unassigned claims. Effective with claims filed on or after January 1. (Section 954)

PAYMENT WHERE BENEFICIARY NOT AT FAULT Requires the Secretary of HHS to make payment under the Medicare hospital insurance program for inpatient hospital or SNF services in those instances where a beneficiary requiring a higher level of care is erroneously placed in a part of the institution providing lower level of care. Effective January 1. (Section 956)

NURSE-MIDWIVES Mandates Medicaid coverage of services furnished by nurse-midwives which they are authorized to perform under state law. Effective for calendar quarters beginning more than 120 days after enactment. (Section 965)

Reimbursement reform

STATE COST-CONTAINMENT DEMONSTRATIONS Authorizes Secretary of HHS to grant (or continue) Medicare waivers for state cost-control demonstrations until the state's reimbursement system is no longer applicable to all third-party payors or no longer meets the required tests of effectiveness in controlling costs. The Secretary is required to continue the Medicare reimbursement system in accord with these requirements for any state which has had a cost-containment demonstration project reimbursement system in continuous operation since July 1, 1977. No more than six statewide demonstration projects could be continued or implemented under this authority.*Effective on enactment. (Section 903)

COORDINATED AUDITS Authorizes coordinated audits under Medicare, Medicaid, and the Maternal and Child Health programs. The Secretary also is directed to evaluate the feasibility of creating a single coordinated appeals process to adjudicate disputes arising under coordinated audits. Effective under Medicaid for medical assistance provided on the first day of the calendar quarter beginning 30 days after enactment. Report to Congress required no later than December 31, 1981, on actions taken to implement this provision. (Section 914)

REIMBURSEMENT OF CLINICAL LABORATORIES Limits recognition of markup of bills from a physician, for services performed by an independent laboratory, to the lesser of the reasonable charge of the laboratory or the amount charged by the physician, plus a nominal fee for physician handling of the specimen. If the physician's bill does not identify who performed the test or give the amount charged, Medicare payment would be the lowest charge obtainable from a local laboratory. Any Medicaid payment for laboratory services billed for but not performed by a physician could not exceed the Medicare amount. Also, the Secretary would report to the Congress within 24 months on the effects of this provision. Effective date: Medicare—no later than April 1; Medicaid—the first day of the calendar quarter which begins 6 months after enactment. (Section 918)

OUTPATIENT SURGERY Provides for reimbursement for costs of certain surgical procedures (as determined by the Secretary) performed in ambulatory surgical centers and for certain procedures expenses associated with such surgery, including recognition of overhead in a physician's office. Such reimbursement would be made for surgery performed in a physician's office only if the physician is authorized to perform the procedures in a nearby hospital and if a PSRO has agreed to conduct review of the physician's performance of such procedures. Physicians would be paid 100 percent of reasonable charges if they accept assignment. Effective on enactment. (Section 934)

PAYMENT TO PROVIDERS OF SERVICES Provides for Medicare reimbursement to providers under part B of Medicare on the basis of the reasonable cost of services minus the coinsurance amounts charged beneficiaries for outpatient services. The law *inadvertently* repeals the "lower of costs or charges" provision for providers under part B. Effective on enactment. (Section 942)

HOSPITAL-BASED PHYSICIAN REIMBURSEMENT Limits the special Medicare 100-percent reimbursement (with no deductible) for radiology and pathology services to physicians accepting assignments for all services furnished to hospital

inpatients. Effective for services provided after the sixth calendar month beginning after enactment. (Section 943)

DETERMINATION OF REASONABLE CHARGES Provides that determination of Medicare reasonable charges for physician services will be based upon the date the medical service was rendered rather than the date on which the claim was processed. Effective with bills submitted or requests for payment made on or after July 1. (Section 946)

SECONDARY LIABILITY OF MEDICARE Provides that Medicare would be the secondary payor in cases where care can be paid for under an automobile insurance plan or liability insurance, including self-insured plans. The Secretary may waive these provisions if he/she determines that the probability of recovery or the amount involved does not warrant pursuit of the claim. The Medicare program would ordinarily pay for the beneficiary's care in the usual manner and then seek reimbursement from the private insurance carrier after, and to the extent that, such carrier's liability under the private policy for the services has been determined. Effective on enactment. (Section 953)

TEMPORARY DELAY IN PIP Provides for 3 weeks deferral of periodic interim payments (PIP). Effective last 3 weeks of September. (Section 959)*

EXPEDITED RECOVERY OF DISALLOWED CLAIMS Allows states to retain disallowed Medicaid expenditures until completion of the administrative appeals process, but requires states to offset these funds along with interest if the denial is upheld. Effective for expenditures made on or after October 1, 1980, which are disallowed. (Section 961)

Administrative improvements

PHILANTHROPY Enacts current Medicare policy regarding philanthropy into statute. This policy provides that the following items shall not be deducted from the operating costs of nonprofit hospitals in determining reimbursement amounts: 1) grants, gifts, or endowments and the income therefrom, which have not been designated by the donor for paying any specific operating costs; 2) governmental grants or similar payments, under the terms of which the grant or payment is not available for use as operating funds; and 3) the proceeds from the sale or mortgage of any real estate or other capital asset which the hospital acquired through gift or grant and which, under the terms of the gift or grant, are not available for use as operating funds (except for recovery of the appropriate share of depreciation when gains or losses are realized from the disposal of depreciable assets). Effective on enactment. (Section 901)

WITHHOLDING OF MEDICAID PAYMENTS Broadens Secretary's authority to withhold federal matching funds under Medicaid to recover Medicare overpayments. Effective on enactment. (Section 905)

QUALITY ASSURANCE PROGRAM FOR CLINICAL LABORATORIES Extends Secretary's authority to conduct the proficiency testing program for clinical laboratory personnel (practical nurses, therapists, and certain other personnel) until December 31. (Section 905)

REPORTING OF FINANCIAL INTEREST Amends Title XI requirements concerning reporting of financial interest. Effective on enactment. (Section 912)

EXCLUSION OF HEALTH CARE PROFESSIONALS Excludes from program participation all categories of health care professionals convicted of Medicare/Medicaid-related or Title XX crimes. Effective on enactment. (Section 913)

CRIMINAL STANDARDS FOR MEDICARE/MEDICAID-RELATED CRIMES Clarifies that criminal penalties apply only when conduct is "knowingly or willfully" undertaken. Effective on enactment. (Section 917)

HOME HEALTH ADMINISTRATION Requires Secretary to take actions to achieve more effective administration of the Medicare home health benefit. Effective on enactment. (Section 930)

BONDING OF HOME HEALTH AGENCIES Requires Medicare home health agencies to meet additional requirements (including the establishment of bonding or escrow accounts) which the Secretary finds necessary to minimize financial risk, as a Medicare condition of participation. Effective on enactment. (Section 930)

REGIONAL INTERMEDIARIES FOR HOME HEALTH AGENCIES Requires Secretary to establish regional intermediaries for home health agencies. Effective on enactment. (Section 930)

PROHIBITION OF PATIENT CERTIFICATION BY PHYSICIANS WITH OWNERSHIP INTEREST IN HOME HEALTH AGENCIES Prohibits physicians from certifying to the need for care or preparing the plan of care for patients of a home health agency in which the physician has an ownership interest or other financial connection. Effective July 1. (Section 930)

PAYMENT FOR HOME HEALTH AGENCY COSTS FOR LONG-TERM OR PERCENTAGE-BASED CONTRACTS Prohibits recognition of costs incurred by Medicare home health agencies which are for contracts exceeding five years, or for which payment is determined based on a percentage of the agency's billing. Effective July 1. (Section 930)

TRAINING OF HOME HEALTH AIDES Requires Medicare home health aides to have completed a training program approved by the Secretary. Effective July 1. (Section 930)

REPEAL OF PRESUMED COVERAGE PROVISIONS Repeals Medicare provisions authorizing, by type of diagnosis, presumed periods of coverage for skilled nursing facility and home health services. Effective January 1. (Section 941)

PLAN OF TREATMENT FOR SPEECH PATHOLOGY Allows speech pathologists to establish the plan of treatment for outpatient speech pathology services under Medicare. Effective January 1. (Section 944)

TERMINATION OF BUY-IN Permits individual whose state buy-in coverage for part B of Medicare has ended to terminate coverage effective with the month HCFA is notified that such coverage is no longer wanted. Effective third calendar month beginning after enactment. (Section 945)*

PAYMENT TO TEACHING HOSPITALS Repeals Section 227 of P.L. 92-603. Would permit reasonable charge reimbursement to physicians in teaching hospitals if the following specified conditions are met: the physician must exercise full personal control over the management of the patient's care; services are of the same character as those the physician furnishes to nonbeneficiaries; and at least 25 percent of hospital's non-Medicare patients must pay all or a substantial part of charges (including the Medicaid payments) for similar services rendered to them. Puts into statute current HCFA principles (Intermediary Letter 372) which provide that a physician must be the patient's attending physician if he is to be eligible for charge payments. Allows cost reimbursement to hospitals where all physicians elect it. Effective with cost-accounting periods beginning January 1. (Section 948)

STANDARDS FOR RURAL HOSPITALS Authorizes Secretary to apply Medicare standards more flexibly to small rural hospitals (50 beds or less) where the health and safety of patients are not jeopardized. (Secretary could limit scope of services furnished by hospital.) Also extends Secretary's authority to waive the 24-hour nursing requirement for such hospitals. Effective on enactment. (Section 949)

CERTIFICATION AND UTILIZATION REVIEW BY PODIATRISTS Allows podiatrists, acting within the scope of their practice, to be recognized as physicians under Medicare for purposes of physician certification and utilization review requirements. Effective January 1. (Section 951)

ACCESS TO BOOKS AND RECORDS OF SUBCONTRACTORS Prohibits Medicare reimbursement to providers for services furnished under contracts (whose cost or value over 12 months is $10,000 or more) to subcontractors unless the Secretary has access to books and records necessary to verify costs. The Secretary's request for access to books and records must be in writing, and the Secretary must specify in regulations the criteria and procedures for seeking and obtaining access to the relevant contracts, books, and records. Effective for contracts entered into on or after the date of enactment. (Section 952)

PRRB JURISDICTION Requires Provider Reimbursement Review Board to determine within 30 days whether it has jurisdiction over an issue brought before it by a provider, and authorizes judicial review without further administrative review where the Board decides it lacks jurisdiction. Effective on enactment. (Section 955)

TECHNICAL ESRD AMENDMENTS Authorizes Secretary to enter into agreements with approved nonprofit agencies which assist Medicare patients to dialyze at home. Effective on enactment. (Section 957)

ESRD REPORT (Section 957) Changes reporting date for Renal Disease Annual Report to July 1. Effective on enactment. (Section 957)

STUDIES AND DEMONSTRATIONS Requires studies on Medicare coverage for orthopedic shoes, respiratory therapy, second opinions for medical surgery, foot care, and home health services of dietitians; calls for demonstrations on coverage for clinical social workers and nutritional therapy for renal patients. Provides that, where relevant, any such study should include an evaluation of the effects of payment to independent practitioners on the coordination of care, cost, quality, organized settings, and utilization of services. Effective on enactment. (Section 958)*

FUNDING FOR STATE MEDICAID FRAUD CONTROL UNITS Authorizes 90-percent federal matching for establishing and operating state fraud control units for the initial 3-year period. After that period, federal funding would be at the 75-percent level. Effective on enactment. (Section 963)

UTILIZATION CONTROL PENALTIES Prohibits Secretary from assessing financial penalties against states for failure to conduct effective utilization review during periods prior to January 1979. (One state, Colorado, is affected.) (Section 964)

DEMONSTRATION PROJECTS FOR TRAINING AFDC RECIPIENTS Requires Secretary to conduct demonstration projects in up to 12 states to train AFDC recipients as home health aides. Effective on enactment. (Section 966)*

Professional Standards Review Organizations*

PSRO MEMBERSHIP Authorizes PSROs to offer membership to nonphysician health professionals who hold independent hospital admitting privileges (effective on enactment); provides that a registered nurse and dentist must be included in the advisory groups of each statewide PSRO Council; expands membership of

National Council to include a dentist, a registered nurse, and one other nonphysician health professional; eliminates requirement for formal advisory groups, and authorizes Secretary to establish more flexible guidelines to assure PSRO consultation with representatives of all health care disciplines. Effective 180 days after enactment. (Sections 921, 922, 923, 927)

REQUIRED ACTIVITIES OF PSRO Permits a PSRO to become fully designated when it is satisfactorily reviewing hospital services; eliminates requirement that ambulatory care review be conducted within 2 years of receiving full designation. Requires Secretary to establish an evaluation program to determine the cost effectiveness of review of health care services in settings other than hospitals and alcohol detoxification facilities. Authorizes the Secretary to assign review responsibility to a PSRO other than the PSRO from the designated area. Effective on enactment. (Section 924)

EFFICIENCY IN DELEGATED REVIEW BY PSROs Authorizes PSROs to delegate review functions to hospitals only if the hospital demonstrates capacity to carry out required reviews efficiently in addition to the current requirements that such reviews be carried out effectively and in timely fashion. Effective on enactment. (Section 925)

PSRO REVIEW Authorizes PSROs to focus preadmission review on elective hospital admissions and related services; authorizes Secretary to direct PSROs to conduct such reviews when they can be made on a timely and cost-effective basis. Effective on enactment. (Section 926)

RESPONSE OF PSROs TO FREEDOM OF INFORMATION ACT Provides that PSROs would not be required to release any records pursuant to a request under the Freedom of Information Act until the later of one year after a final court order for release, or the last day of the Congress during which the court order was entered. Effective on enactment. (Section 928)

STUDY OF PSRO NORMS Requires Secretary, in consultation with National PSRO Council, to conduct a study of PSRO norms and criteria, including an assessment of the rationale for regional differences. Secretary shall report findings within one year of enactment. Effective on enactment. (Section 929)

Long-term care facilities

DIFFERENTIAL REIMBURSEMENT Authorizes reimbursement at the state Medicaid ICF or SNF rate where patient requiring lower level of care under Medicare and Medicaid is inappropriately placed in the hospital; reduced reimbursement does not apply for first 2 years where hospital's occupancy is over 80 percent. Effective on date final regulations are issued (not later than first day of sixth month after month of enactment.) (Section 902)

SWING BEDS Provides swing-bed reimbursement for small, rural hospitals which have been granted a certificate-of-need for provision of long-term care services. Provides swing-bed demonstration authority for larger hospitals. Effective on date final regulations are issued (no later than first day of sixth month after month of enactment). (Section 904)

LIFE SAFETY CODE Authorizes Secretary to determine when SNFs would be required to meet provisions of revised editions of Life Safety Code. (Facilities meeting the 1973 or 1967 edition would be "grandfathered.") Effective on enactment. (Section 915)

INTERMEDIATE SANCTIONS FOR SNFs AND ICFs Authorizes Secretary to impose intermediate sanctions for SNFs or ICFs which are out of compliance with conditions of participation less severe than decertification; i.e., denial of reimbursement after a designated date to out-of-compliance SNFs until facility corrects deficiencies (if not corrected after one year, the Secretary may decertify the facility); authorizes Secretary to "look behind" state agency surveys on SNF and ICF compliance with conditions of participation in situations where the Secretary has cause to question the adequacy of the state's determination; allows states to impose intermediate sanctions, under Medicaid, upon SNFs and ICFs. Effective on enactment. (Section 916)

STUDY OF DUAL PARTICIPATION OF SNFs Requires Secretary to study the availability of SNFs under Medicare and Medicaid and the effect of requiring all SNFs which participate in Medicare to also participate in Medicaid (and vice-versa). Study and recommendations must be submitted to Congress within one year of enactment. (Section 919)

ALCOHOL DETOXIFICATION FACILITY SERVICES Provides for Medicare reimbursement of inpatient detoxification services (related to alcoholism) in free-standing facilities. Effective April 1. (Section 931)*

TRANSFER FROM HOSPITAL TO SNF Changes to Medicare requirement that patients be transferred from a hospital to a SNF from within 14 days of discharge to qualify for posthospital extended care benefits. New requirement is 30 days. Effective on enactment. (Section 950)

MEDICAID LONG-TERM CARE REIMBURSEMENT Repeals the requirement that SNFs and ICFs under Medicaid be reimbursed on a reasonable cost-related basis. States can develop methods and standards on which rates of Medicaid reimbursement are based with the Secretary having 90 days to approve or disapprove. These rates must be reasonable and adequate to cover the costs of an efficiently operating facility. If not acted upon within 90 days, rates would take effect for the fiscal year for which they were proposed. Effective October 1, 1980. (Section 962) ■

WHAT'S FAIR?

Financing Health Services Raises Ethical Questions

by Margot Joan Fromer

To what extent can and should ethical criteria be applied to the financing of health care? What role do personal and societal values play in health policy and administrative decisions, and to what extent should government be involved in these decisions? How should the distinction between individual rights and the common good be applied to provision of health care, or should such a distinction even be made?

Today, the basic ethical problems in health care are access and allocation—how to make the best possible care available to all people needing it, while keeping costs affordable. However, no unanimity of opinion has been reached on the definition of goals relating to access and allocation of care. For example, are there kinds of health care that are simply too expensive to be considered a practical treatment goal? Is anyone worth the approximately $100,000 that a totally implantable artificial heart (TIAH) would cost? If both you and I want a TIAH, which of us would receive it? How and by whom should the decision be made?

That some people in the United States receive health care that is inferior in quality and quantity to that received by others is no surprise to anyone working in the health care system. An American's income, social class, and residence often predicts accessibility to health care and the kind of care received. Many health professionals probably would agree that in these respects the system is unjust and sometimes downright inhumane, and that something should be done about the inequities.

More money is not an assured solution—even if added funds could be found and agreement were reached to spend them on health care. Many feel this might simply enlarge the problem to a grander scale. If more funds were allocated by Congress to be used for health care, they might not necessarily be used to equalize access and allocation. Instead, they might be earmarked for the development of even more high technology, which has been the traditional preserve of those who can afford to pay.

Various governmental and private bodies are exploring these ethical problems, either in the course of administering public programs (as in the case of the Health Care Financing Administration and certain state boards) or as a subject for research (three such groups are the Institute of Society, Ethics, and the Life Sciences, also called the Hastings Center; the Kennedy Institute; and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research).

There is a sense of urgency behind all these considerations. Even while

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officials labor to draft rules and regulations and researchers contemplate history and principles, they know that quick, painful decisions are being made in hospital corridors, emergency rooms, physicians' offices, and operating rooms, concerning treatment and care. The consequences can be devastating, for individuals, families, and society.

"Equal access" to care is probably an impossible goal.

This article explores some of the ethical problems of access and allocation facing the health care system (especially Medicare and Medicaid), the decision-making processes involved, organized study and research on the subject, and some possible solutions.

Equal access . . . for whom?

We know that disparities in access to health care often reflect income, residence, age, race, and similar variables. Because such disparities are commonly believed to be unfair, they should be evaluated. For example, is it justifiable to eliminate persons over age 55 from heart transplant candidacy? Is age alone an ethically relevant criterion, and if so, on which principles is it based? If a family happens to live an inconvenient distance from health services, do we simply say, "tough luck," or do we make an effort to bring provider and recipient closer together? If so, how close, how often, and under what circumstances?

"Equal access" is a current buzz word in bioethics. How literally should "equal" be interpreted, and what criteria should be used to achieve that elusive, rather amorphous goal? Does it mean that every person in the United States should have exactly the same access to the very best quality care, regardless of cost or prognosis? If so, by inference, all individuals must have the highest quality care simply because the best exists, will be sought by some, and therefore cannot be denied to others. This is probably an impossible goal, but where should the line be drawn on the continuum of both quality and availability of care?

If "equal" is interpreted in any other way regardless of how slight the deviation from the literal, the door remains open to continuation of two-class, health-care delivery. With less than equal access, we come to the issue of a "decent minimum," a phrase coined by Charles Fried, professor of law at Harvard University. The decent minimum is an amount of health care that would be provided equally to everyone, with options to purchase more: a standard less rigorous than absolute equality of access and allocation. Inherent in the concept of a decent minimum are questions of justice, fairness, and rights; the problem of deciding which services would constitute "minimum" or essential care; and the matter of singling out health care as a societal benefit to undergo this kind of scrutiny and subjection to ethical evaluation.

In an article, "An Analysis of 'Equality' and 'Rights' in Medical Care,"* Fried holds that defining a decent minimum is essentially a political process and that a right to health care does not necessarily imply a right to equal access. He believes "equal access" to be a dangerous political slogan that in reality would mean unreasonable expenses or intolerable government controls.

Society need not single out health care as a model of equality of access when other societal benefits, such as education and housing, do not fall under the same rubric, Fried maintains. (Although there are safety standards in housing and laws concerning minimum schooling, equality is not the theoretical underpinning of these social benefits.)

His opponents maintain that, while there may be no historical basis for equal access to health care, society has only recently developed the technologic means to provide the care, and equality of access had little meaning prior to this development. Moreover, that certain segments of the population are denied high quality education and other benefits does not justify carrying unequal treatment over to the delivery of health care.

But health is unique, some believe, because it is a precondition for other benefits, such as employment and the ability to participate in and enjoy other aspects of life. It can be argued with equal justification, however, that benefits such as adequate food and housing are preconditions for optimum health.

Fried proposes that restrictive activities of those who control the provision of health care (mainly physicians, whose practice he describes as "guild-like and monopolistic") be loosened and that each individual be assured a certain amount of money to purchase those health services he or she chooses, thus letting the consumer establish his own decent minimum.

Health care competes for resources

Allocation of resources is the second major category of ethical problems in health care financing. First the Nation must determine what percentage of its total resources should be used for health care and its priorities for distributing that care. This is called macroallocation. Of course there are competing priorities—defense, education, space exploration, energy conservation, interstate highways, research in the humanities, and the thousands of other benefits we have come to expect and feel we cannot live without.

For example, is health care more or less important than the exploration of the solar system? If they are equally important, should both receive equal funding? If they are not, what criteria will be used to determine relative importance?

Deciding what portion of the total allocation will be spent on which aspects of health care comes next. This would include determining the relative value of heart disease prevention as compared with infant immunization programs, or neonatal research with respiratory disease control. Several conflicts are involved. The first is the role of government: should it be in the health care allocation business at all, should the allocation of all goods and services be left to the open market, or should government have a partial role in allocation?

*Hunt, Robert, and John Arras, eds. *Ethical Issues in Modern Medicine,* Mayfield Publishing Co., Palto Alto, 1977.

A second conflict is over priorities for the distribution of *all* societal goods and benefits, including health care. Are decisions to be made on the basis of lives saved, suffering eased, or money spent? The principle of justice, which one could hope would be used to solve these conflicts, does not always work when translating abstract concepts to the solution of real human problems.

The choice between protecting life and health through treatment, on one hand, and preventing death and disease, on the other, presents further possibilities for disagreement. Which should receive greater funding? Should macroallocation concern itself more with high technology, such as developing improved kidney dialysis machines or an artificial heart, or should money be spent on mass education about health and prevention of disease, such as vigorous anti-smoking campaigns and mass screening programs?

Many think it is more economically and socially beneficial to prevent disease, but how would society feel if it devoted less than full energy and resources to treating the ill?

Another aspect of the conflict is determining which health problems deserve the highest priority—those that kill the greatest number of people, such as heart disease or cancer, or ones that involve a chronic, though less critical disability, such as diabetes or arthritis.

Microallocation: life or death?

But, assuming that not all can invariably receive all needed and available heath care services, which individuals should receive them? The microallocation problem sometimes involves life and death dilemmas. Ethical problems in microallocation generally revolve around selection criteria and the persons making selection decisions. As a result of policy decisions, some people may suffer death or severe and irreparable harm, while others are saved from such a fate.

The most obvious example of this is the End Stage Renal Disease program (administered by HCFA). Many more people died of kidney disease before Congress legislated funds, as an amendment to the Social Security Act, for provision of dialysis to all who required it, regardless of how promising or bleak the prognosis.

But this aspect of the microallocation problem was by no means solved (many believe it was further complicated) by Congress' action, and other seemingly unsolvable dilemmas remain. For example, now that no one need be denied dialysis, there are many kidney patients who are suffering from severe, even terminal, illnesses in addition to renal disease. These persons will likely die soon of their other diseases or at the very least not recover from them. Should they be permitted access to dialysis, or should they be refused and the money thus saved be put to other good uses? (The complexities of the ESRD program were discussed in *Forum's* August 1980 issue.)

In other situations medical criteria are used to eliminate from consideration those persons least likely to benefit from a particular treatment or procedure.

Then too social worth is believed by many to be a justifiable criterion, although it is impossible to differentiate among and assign priority to a variety of characteristics, such as societal contribution, education, occupation, family status, and the like.

Random selection, either natural (first come, first served) or artificial (a lottery), is often suggested as the fairest, most democratic criterion. Proponents defend it on several grounds. Randomness preserves human dignity (which the criterion of social worth might not) and provides equality of opportunity. It does not depend on a relationship between health care provider and client that might be based on differing values or personal preference, nor does it depend on a rank order that compares individuals or puts them in a competitive position. Moreover, many believe that rejection based on random selection is psychologically easier to bear than that based on social worth. This criterion for saving lives when not all can be saved may be the most nearly perfect in terms of justice and is difficult to fault on a theoretical basis.

But critics see random selection as irrational, irresponsible, or even inhuman ("What if a derelict were selected and a Supreme Court Justice left to die?").

Another criterion would be to permit *no one* access to available life-saving treatment, unless everyone has access. Although instituting this criterion might spur quick allocation of (perhaps nonexistent) funds, it is generally regarded as an untenable ethical position, tantamount to deliberately causing death or irreparable harm to vast numbers of people.

Making decisions in real life

Abstract discussions of ethical problems in health care go on, but real life policy decisions concerning access and allocation of health services are difficult to make and may have devastating consequences. For example, HCFA sets policy for determining the coverage of services provided under Medicare and Medicaid. A treatment or procedure may be covered if it is reasonable and necessary and therefore thought to be safe and effective. (In addition, the procedure should not be experimental.) HCFA consults with the Public Health Service and other health care experts to determine safety and effectiveness, but the terms are sufficiently vague to leave the criteria open to endless interpretation and debate.

Is health care more or less important than exploring the solar system?

This vagueness contributes to ethical dilemmas. If a procedure is considered questionable or is thought to be experimental (for example heart transplants or transexual treatment and surgery), HCFA officials consult with the National Center for Health Care Technology (NCHCT) for research, study, and recommendation. The NCHCT may convene a panel to study the safety, efficacy, and research status of a particular coverage problem. Other components of PHS may be asked to provide information bearing on the problem or to conduct independent research. Also, professional

organizations and societies may be asked to provide advice. After analyzing the data, NCHCT gives HCFA a short summary of the safety and efficacy of the procedure in question, with a recommendation for action.

The decision-making process of NCHCT panels is complex and sensitive. Transexual treatment and surgery provides an illustration of the determination of safety and efficacy. For example, although the various surgical operations necessary for transexualism are safe in the usual sense of postoperative morbidity and mortality, it has been found that many transexuals suffer from an unusually high incidence of recurrent bladder and urethral infections; therefore, overall safety of the procedure is diminished.

Moreover, efficacy of transexual treatments and procedures is controversial. How can one determine the transexual person's potential for effective functioning in terms of self, significant others, and society in general, especially when compared with the individual's functioning were the original gender not changed? Is transexual treatment and surgery generally beneficial? Because empirical evidence on psychological and sociological aspects of the subject from long-term studies is scarce, it is difficult to assess such remedies.

For kidney patients, equal access to care has been achieved.

Heart transplants offer another dramatic example of how ethical decisions can be influenced by economic, social, and political considerations. For a number of years, such transplants were not covered under Medicare, because they were considered experimental. In late 1979, however, HCFA decided to cover heart transplantation on an interim basis, but only for procedures performed at the Stanford University Medical Center. This was done on preliminary findings of the Public Health Service—a scientific panel, meeting under the auspices of the National Heart, Lung, and Blood Institute of PHS, concluded that heart transplants as done at Stanford were safe and efficacious (NCHCT concurred).

Another institution brought successful action before an administrative law judge to have its heart transplants also covered under Medicare; but HCFA maintained that it lacked data to prove safety and efficacy of the procedure performed elsewhere than Stanford. HCFA admitted that the issues involved were multiple and complex.

Are women entitled to amniocentesis simply because it is available?

As a result, then-Secretary of HHS Patricia Roberts Harris decided to exclude Medicare coverage of all heart transplantation, acknowledging that there were many unanswered questions about the value of the surgery and that patient selection and economic and ethical considerations were among the factors that influenced her decision.

The decision drew criticism. Dr. Donald Kahn, professor of surgery and chairman of thoracic and cardiovascular surgery at the University of Wisconsin, Madison, accused HHS of "picking on" heart transplant surgery, pointing out that the survival rate for heart transplant recipients is as good as for those receiving kidney transplants.

Since Secretary Harris's decision, HCFA has announced the start of a broad study, in cooperation with NCHCT, of the "scientific, social, ethical, and economic" issues involved in heart transplantation, to determine whether such surgery should be covered by Medicare in the future.

Of course, the issue at HHS was never "banning" heart transplants, because patients with private insurance or sufficient means could continue to obtain them. Rather the issue was denying transplants to elderly and disabled Medicare beneficiaries who had no other way to pay for them.

Such decisions by the Federal Government can have unexpected consequences. For example, when Congress decided to provide funds for every individual who required dialysis, the number of dialysis recipients increased by 500 percent, so that 4 percent of the Medicare budget is now used for 0.2 percent of the Medicare population. For kidney disease patients, equality of access to care seems to have been achieved.

Studying ethics of care, dollars

Although these ethical problems may appear to be almost unsolvable, there are organizations set up to research, among other things, problems of health care financing. Among the most prominent are the Institute of Society, Ethics and the Life Sciences (The Hastings Center) at Hastings-on-Hudson, New York, and the Kennedy Institute at Georgetown University in Washington.

The Hastings Center is an interdisciplinary research organization that plays a major role in increasing public and professional awareness of ethical issues in health and medical matters. The center's three goals are: advancement of research, stimulation of unversities and professional schools to support the teaching of ethics, and public education.

Concern with research and teaching on many of the same issues is the focus of the Joseph and Rose Kennedy Institute of Ethics at Georgetown University (of which the Center for Bioethics is a part). In addition to their research and public service activities, many Kennedy Institute scholars hold faculty appointments in Georgetown's philosophy department, where an increasing number of graduate students are focusing their studies on bioethics.

Several state and federal agencies also have boards or panels that convene especially to consider ethical issues in health care. Noteworthy is the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.

The Washington-based Commission is a government agency, mandated by public law in 1978. More than an advisory commission, it does not establish policy, but does recommend policy and reports to both the Congress and the President.

While the Commission's mandate is to examine a broad range of ethical issues, the financing of health care pervades much of its work. (It is almost impossible to research any component of health care ethics without considering the financial aspects or doing a cost/benefit analysis.)

For example, one of the Commission's topics, defining the point at which death has occurred, might seem to be nonmonetary. Yet there are clear economic implications to a closely related subject—prolonging life for terminally ill patients through extraordinary means. Does the patient have the right to choose death or refuse treatment? Might not the money spent on such maintenance be better allocated to other health services?

Although the commission is interested in economic problems, it is not money *per se* to which they turn their attention, but how and on whom money will be spent. The allocation problem, however, goes beyond the distribution of funds; it also touches on why money should or should not be spent in particular ways.

Selection criteria must be simple, plausible, says philosopher.

For example, one subject the Commission will be considering is amniocentesis, a widely used screening device for pregnant women who want to know if they are carrying a fetus with certain deformities. Should it be used on all medically eligible women, at a high total cost or only those who agree beforehand to abort a deformed fetus, thus minimizing costs? Or are women entitled to the information provided by the procedure simply because it exists? And what of the woman who changes her mind later in the pregnancy and requests amniocentesis when it is too late for an abortion? Is there an ethical middle ground, and if so, where?

The Commission recently held public hearings on access to care, considering such questions as: are there current disparities in access; if so, how are they measured; and should there be universal access?

The Commission studies the ethical components of health care decisions; that is, are decisions consistent with deeply held ethical values, and to what extent should cost be figured into decisions that have an ethical base? This potential conflict between financial reality and the ideal of correct behavior underlies the study of all problems dealing with the financing of health care.

How to allocate fairly?

Although only a small fraction of the dilemmas described above involve a matter of life and death, all affect the quality of life for people who are the subject of health care policy, that is, nearly every American. Those with greater wealth or more familiarity with the health care system have a greater freedom of choice than those not so advantaged, but matters of access and allocation ultimately affect everyone. Most people would agree that current policies concerning ethical decision-making are vague and haphazard, contributing to an inequity in the distribution of medical services.

How can the situation be improved so as to make the availability and allocation of health services more fair? One interesting solution that combines an assessment of an individual patient's social worth with an element of chance is proposed by philosopher Nicholas Rescher. In his article "The Allocation of Exotic Medical Life-Saving Therapy*," he asserts that criteria for selecting patients to receive such therapy must be simple enough to be intelligible; plausible enough that the average person can understand them; justifiable in the minds of most people; and rationally defensible. Most important, he believes, is fairness—like cases must be dealt with equally, leaving no room for influence or favoritism.

To meet as many of these requirements as possible, Rescher suggests the following decision-making process:

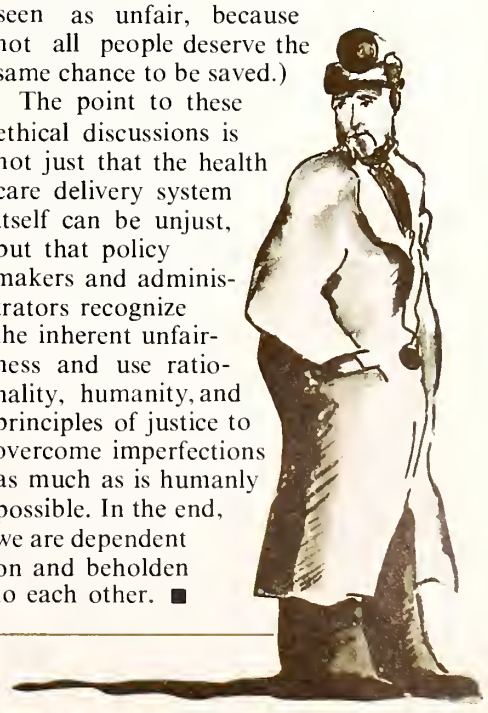
- *Stage 1.* Patients judged in need of a life-saving therapy would be first considered in terms of three factors: *constituency,* or groups eligible for the therapy in any given institution (e.g., children would not be constituents of VA hospitals); *progress of science,* or the needs of medical research to produce future benefits; and *prospect of success,* or how likely the treatment would be to succeed. A considerable number would be eliminated from consideration at this stage.

- *Stage 2.* The group of patients not eliminated in Stage 1 would then be screened on the basis of five more factors: *relative likelihood of success; individual life expectancy; family role; potential future contributions;* and *past services rendered.* After further eliminations based on these factors, the group remaining would be about one-third or one-half again larger than the final number to whom the therapy could be given.

- *Stage 3.* Final selection would be made by *random choice,* as long as there remained no significant disparities among applicants.

Rescher's selection process addresses only the microallocation of health care resources and makes some assumptions about the equality of access. But the principles involved and elements of the process itself could be translated into solutions for other problems in health care delivery. Any solution will be imperfect, however, because all elements of unfairness and injustice cannot be eliminated. (Even a lottery can be seen as unfair, because not all people deserve the same chance to be saved.)

The point to these ethical discussions is not just that the health care delivery system itself can be unjust, but that policy makers and administrators recognize the inherent unfairness and use rationality, humanity, and principles of justice to overcome imperfections as much as is humanly possible. In the end, we are dependent on and beholden to each other. ■

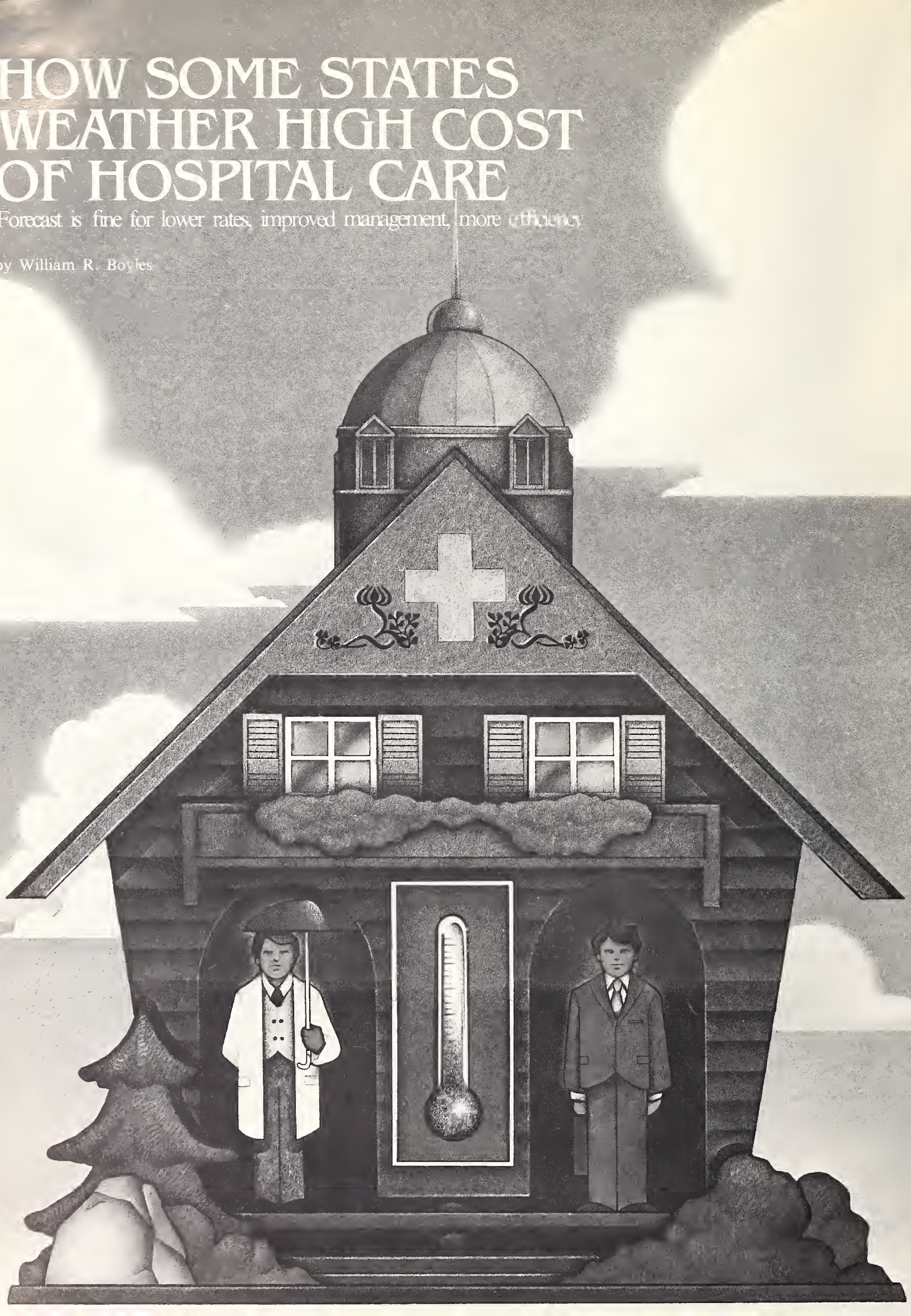


*Ethics, University of Chicago Press, 79(3): 173-186, April 1969.

HOW SOME STATES WEATHER HIGH COST OF HOSPITAL CARE

Forecast is fine for lower rates, improved management, more efficiency

by William R. Boyles



After more than ten years of scattered experience in hospital rate regulation, there is still widespread disagreement over what works best to both reduce hospital costs and improve hospital management. A search is on to identify which elements of hospital rate-setting systems pass the test of being fair as well as efficient.

TELEVISION LIGHTS GLARED ACROSS A crowded conference room in Baltimore last September as Dr. Carl J. Schramm, director of the Center for Hospital Finance and Management, Johns Hopkins University, announced the findings of the latest study* on hospital rate regulation: Six states already had in place programs significantly reducing the nation's growing burden of hospital costs, using mandatory state rate-setting.

By the end of that day, the television networks and many newspapers across the country carried stories that out-of-control hospital cost increases might in fact be controllable, if more states would adopt their own rate-regulation programs.

A month earlier, the U.S. Government Accounting Office reported to Congress** that nine states with rate-setting programs kept cost increases well below comparable states lacking such controls and showed improved management as well.

So go the latest installments in what has become a major consumer issue and public policy headache for the coming decade: how to reduce the burden on state and federal budgets (and consumer pocketbooks) from the increasingly complex, ever more expensive U.S. hospital system. And how to do it without bankrupting hospitals or squeezing out needed services in communities nationwide.

The fact that Schramm and his colleagues drew such wide media coverage attests to the growing visibility of the issue. Yet, for a number of years, there has been consumer and industry pressure on legislatures in at least two dozen states to restrain hospital spending.

While on Capitol Hill the battle raged over mandatory hospital revenue limits, many states were launching their own experiments in state-level rate regulation. The result is a mixture of programs so diverse they defy both categorization and conclusions over why some hold costs back and some do not. Even the programs in the Schramm study share little in common besides being mandatory.

About 30 states set rates in some way—usually rates that apply only to Medicaid and Blue Cross/Blue Shield reimbursement, but not Medicare. Seventeen states have legislative authority for their efforts, and eight or nine of these have mandatory rate-setting, although this seems to be in a state of flux.

The Health Care Financing Administration's Office of Research, Demonstration, and Statistics has launched a number of research projects aimed at finding out if the realities of rate review live up to the promises.

These studies should provide more tangible evidence of which specific factors in the myriad of programs deserve more widespread application. In the meantime, the debate continues: how effective is rate regulation generally in reducing the high cost of hospitalization—and is the time ripe to promote rate regulation as a viable alternative to more stringent forms of hospital cost reduction?

States differ widely in approach

Not by coincidence, the crazy quilt pattern of state rate regulation emerged in the early 1970s, when public concern over double-digit hospital costs first surfaced. States like New York and New Jersey were prodded into adopting an unprecedented degree of public control for essentially the same reason: direct or indirect pressure from the purchasers of health services. But that is about where the similarities between the various programs end.

For instance, New Jersey adopted a new system in 1969 in response to pressure to restrain Blue Cross premiums, but that same year, New York set up its program in response to a crisis in the state Medicaid budget.

Two years later both Arizona and Maryland established their own versions of rate review—but for largely different reasons. The Arizona business community, stung by rising employee benefit packages, was the prime mover in the Arizona initiative. In Maryland, a number of converging interests produced an unusual alliance of state, hospitals, and insurers.

In fact, if there is any pattern to the way the two dozen or so rate review systems developed in the early seventies, it is not readily apparent. The major objectives of each system varied considerably. Some programs were established to curb the actual rates and prices that hospitals charge. Other were designed to curb the total expenditures of each hospital in the state, to prevent Blue Cross and private payers from paying more than Medicaid would for similar services, or simply to avoid the prospect of a more stringent federal program and to prove that voluntary systems work.

Perhaps the best perspective on the rate regulation family history can be found in the *First Annual Report of the National Hospital Rate-Setting Study,** a HCFA-sponsored, on-going research project that is providing reams of information on the mechanics of rate-setting.

"While the dominant concern in each of the states was the rising cost of health care, the initial programs reflected key compromises that were forged during the adoption process," this report notes. The variety of political, social, and economic interests in each particular state resulted in

*Biles, Brian, MD, MPH, Carl J. Schramm, PhD, JD, and J. Grahm Atkinson, D-Phil., "Hospital Cost Inflation under State Rate-Setting Programs," The *New England Journal of Medicine,* 303:664-668, September 18, 1980.

**GAO, "Rising Hospital Costs Can Be Restrained by Regulating Payments and Improving Mangement," September 19, 1980.

*HCFA, *"First Annual Report of the National Hospital Rate-Setting Study: A Comparative Review of Nine Prospective Rate-Setting Programs,* Health Care Financing Grants and Contracts Reports, August 1980.

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a homemade system tailored to the competing pressures at work when the program was designed.

In the early days, states also targeted hospital rate regulation at specific areas, such as Medicaid costs or the prices charged one type of payer—Blue Cross, the private insurers, or even individuals. What this created was a network of starkly individualistic systems, each trying to contain costs for its own reason in its own way.

"The economic and political circumstances existing at the time of adoption and the compromises arrived at by countervailing interests have influenced not only the initial characteristics of programs, but their implementation strategies and evolution over time as well," the report adds. Once a framework is established, chances are not as favorable for big changes to be made as times change.

Improving the mechanisms

As the first few years passed, however, hospital rate review changed in subtle, but important ways. It became increasingly obvious that the narrow focus in some states on particular hospital costs created a leaky, fragmented system in the eyes of many involved, including the hospitals themselves. And states began to recognize that some approaches work better than others.

Some programs that began as voluntary systems became mandatory, received the backing of state law, and expanded their scope to include more payers or services. Others switched to a different form of review or type or organization, or made changes in their powers to add more detailed procedures.

"They have improved on the mechanisms by adopting procedures for review by exception. If a hospital's overall budget passes a half dozen or a dozen aggregate screens, they don't go and submit the budget for very detailed review and extended negotiations," explains Craig Coelen, of ABT Associates, Cambridge, Massachusetts, director of the rate setting study project.

"I think that has saved manpower, saved money, and also reduced the friction between the program and the hospital," Coelen says.

Changing to a different type of organization has been one of the most visible ways states have responded to the perceived need for more stringent programs. The use of commissions has been promoted by some hospital industry representatives, as opposed to stricter administration of the system by a state agency or private organization.

But the movement is not strongly in one direction, Coelen says. "There does not seem to be a move by all of them to go to independent commissions . . . some seem determined to stay housed in the state department of health. They do seem to be becoming more formulary in their approach—less face-to-face negotiations with the hospitals. So there are tendencies, but no single model that everybody is moving towards."

Any change, whatever the degree or direction, may depend upon the particular political environment and economic situation. The more pro-competition and anti-regulation the state government, the less frightful the cost crisis, then the slower the implementation of the program and the less stringent its impact. But in areas where hospital costs are rising dramatically, stricter measures are more likely.

Different factors in common

This is how things got to be as they are. But how important are the differences between state programs and do they affect actual performance?

Much of the information needed to answer these questions is still in the process of being gathered by the rate-setting study and other research projects. But early returns suggest that many factors built into rate regulation may significantly alter the way a system operates—and perceptions of its success.

To prove this, one need only ask for an opinion of rate regulation from a hospital administrator, an insurance executive, a state health official, and a business leader—then try to come up with areas of agreement. Concensus is remote. Virtually no two parties agree on where things stand, and spread over two dozen systems, this disagreement is multiplied greatly. The importance of identifying the factors upon which agreement can be reached becomes obvious.

Rate regulation is essentially a form of "prospective" payment to hospitals for services not yet performed, based on expected volume and price.

Yet there are dozens of variations in what services are covered by the process, how volume and price are calculated, who decides the final payment level, the mechanism for appealing the decision, and how reductions in rates are absorbed:

- *Structure.* Who gets the final word on what the hospital will be paid and who controls the pursestrings? This is one of the big differences among states. Many states give this power to a commission, with either government employees or joint government/industry cooperation among staff. Other use very centralized rate-setting within a government health agency or decentralized regulation by health planning agencies or a state hospital association. In some areas, Blue Cross or private insurers decide the rates. What does this mean in terms of performance?

"If you have two programs, similar in other major respects, but different in the type of agency that's responsible for administration—one a commission and another, say, a hospital association or Blue Cross—you would tend to find more public participation and consumers involved with a commission," says Coelen.

Public input has its pros and cons. On one hand, it translates into less technical expertise, and opportunities for co-opting the system are more available. But in a commission that contains sufficient public representation, there is also the opportunity for more public support than might be evident in a closed system.

The commission approach offers the advantage of apparent insulation from conflicts of interest and political pressure, as well as qualified staff, due to more stable salaries and employment policies. But commissions also may be less effective in restraining costs. Centralized rate-setting in a government agency may achieve this goal, but

invite complaints over its motives and objectivity. Decentralized rate-setting and voluntary regulation may be subject to the same criticism.

• *Authority.* Perhaps more critical than the structure is the extent of a program's authority. Systems that cover all payers and hospitals, allow little negotiation, cover total hospital revenues and not just individual rates, and coordinate their efforts with the health planning system, and whose decisions are final mandates, are naturally more likely to be tougher than others.

But the locus of rate-setting authority and organizational mode do not, of themselves, assure stringency and equity, the rate-setting study report finds. This is because a program with a tough legal and administrative arrangement frequently is contained in a less rigid organizational mode. A commission may appear to be independent from industry or state government pressure, but have limited authority and a process that cancels out the benefits of the commission structure. By the same token, private regulation may carry sufficiently strict authority that it makes tougher than a commission.

"Commissions are not inherently more or less open to negotiation than are state agencies," says the study.

• *Procedures.* Mixed in with these two variables—how a state program is set up and how much power it has—is a laundry list of differences in the detailed procedures used. Procedures can "nickel and dime" a system into a quagmire or make things purr. Although rarely considered alone, these factors are important. Included are:

Types of screening or formulas used to trigger more detailed review, methodology used in setting rate or budget increases, coverage of bad debts, charity care, teaching and research costs, and recovery of working capital. How and when will compliance be obtained and adjustments made, once the final curtain is closed?

One hospital industry official explained: "A nation of tinkerers will take any system and tinker with it. The more complicated the system is, the easier it is to work around it. So, I think what we're starting to relearn in this country is that, while you don't want simplistic answers, you need a level of simplicity to assure that things work."

• *Legal viability.* Finally, the degree to which the entire rate-setting process is responsive to the legal requirements of due process and can stand challenges of its final determinations can make or break a program.

Systems that follow specific procedures and well constructed policies under exacting state laws, keeping an extensive public record, are less subject to legal delays and cots. In this area, some programs have encountered almost no legal resistance, while others have spent months in court—and been crippled in the process. The trick is to provide enough flexibility to allow legitimate challenges to be made, without creating a paperwork monster that stalls the whole road race.

Rate setting: Is it effective?

With all the variables, is it possible to compare rate-setting states to those without such programs and judge effectiveness?

In recent months, two major studies—Schramm's and GAO's—have concluded that mandatory rate-setting has worked well to both reduce government expenditures and improve hospital management.

Schramm focused on six states with comprehensive, legally-mandated programs from 1974-78. These included mostly states that have in place programs emphasizing cost containment and stringency. He and his associates found that the average annual rate of increase in expense per admission (a different measure than GAO's) in rate-setting states was 11.2 percent over four years, compared with 14.3 percent in states lacking any program.

"We conclude that much of the initial pessimism regarding the effectiveness of hospital rate-setting programs, based on studies that covered earlier periods, may be unwarranted," the synopsis of the study in the *New England Journal of Medicine* declared.

The GAO study, reported to Congress last August, also contained positive findings. According to the report, nine states with mostly mandatory rate-setting schemes recorded smaller increases in costs per case than did states with traditional payment methods over a three-year stretch.

Consensus on state regulation of rates is remote.

"Further, states with programs which require all hospitals to participate and which approve charges, expenses, or revenues were more successful in controlling cost increases" than voluntary private programs, GAO found.

GAO: Seven "essential elements"

The Congressional watchdog agency also concluded that there is a connection between program effectiveness and seven "essential elements" of rate regulation: uniform reporting of costs and uniform accounting, a coordination of health planning and rate-setting, focus on total hospital expenditures (including utilization), coverage of all payers, mandatory coverage of all hospitals, use of statistical screens, and an appeals and exceptions process allowing hospitals to question rate decisions.

Finally, GAO surveyed health care experts to learn what hospitals can do to improve management under rate regulation. The experts named preadmission testing, admissions scheduling, departmental budgeting, patient classification systems to help in nurse staffing, energy conservation, generic drug purchasing and more use of drug formularies, shared services and equipment, and group purchasing as ways hospitals can, to some degree, hold down the growing cost of their services.

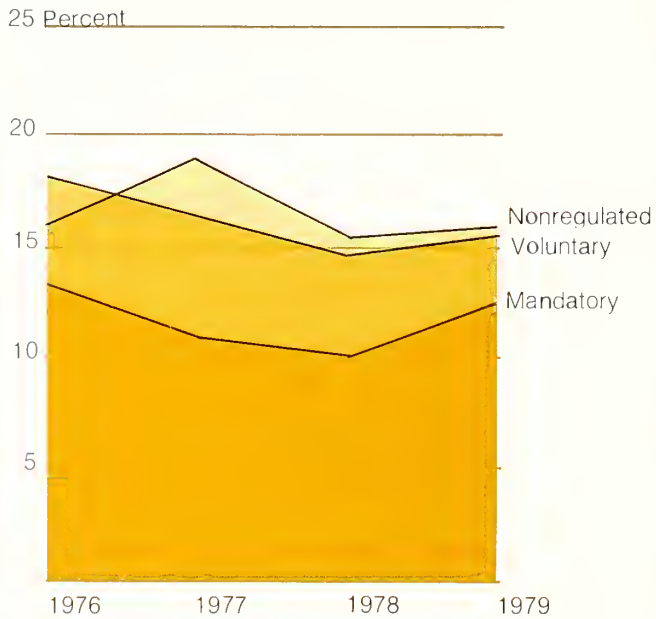
From all this, GAO concluded that "the primary effect of prospective rate-setting programs has been improved hospital budgeting techniques and increased cost awareness by hospital personnel." It recommended that Congress encourage more HCFA participation in rate-

setting programs and that HCFA encourage use of the "essential elements."

The Schramm and GAO studies drew both acclaim and criticism from the field. Several hospital associations and one national health insurance association questioned the degree to which management improvements can strongly influence hospital costs and suggested more research to identify the impact of rate-setting on specific management improvements as well as the quality and availability of services. The observation also was made that non-regulated states may need faster growth to catch up with the regulated states' higher level of services—and again, more research is indicated.

The American Hospital Association included in its criticism a chart showing that total hospital expenses increased much faster in non-regulated states between 1976 and 1979 (see Figure 1). But AHA argued that the reasons are very different from GAO's.

Figure 1.
Annual Rate of Growth of Total U.S. Hospital Expenses: 1976-1979



Source: American Hospital Association, Policy Brief 28, *Persepctives on Rate Regulation*, September 17, 1980

"Environmental factors have played a key role in determining the diffcrences in performance between the two groups of states," according to an issue paper prepared by AHA's office of Policy Studies.

At the same time a number of state health departments, rate-setting authorities, and health insurance associations hailed the GAO studies and supported the call for increased research and development in rate-setting methodologies.

Looking for answers

Despite all the new information about how rate regulation works, James Kaple, director of research, demonstration, and statistics for HCFA, maintains that there remain a number of unanswered questions. What can one program learn from the others to avoid costly mistakes? Which types of rate regulation should be encouraged through the participation of Medicare and other payers not now involved in a particular program?

HCFA's national rate-setting study is a milestone in producing documented answers with direct applications. In addition, HCFA is funding reimbursement demonstrations that test prospective payment in seven programs, has brought Medicare into three programs, and is considering expanding further.

One of the most ambitious—as well as controversial—research efforts involves the use of payment by diagnosis instead of by procedure. Payment rates are set in advance for each category of diagnosis, and the mix of services used to treat the patient in the diagnostic group is determined by the hospital. New Jersey is now ironing out the many bugs in the approach through limited use in a sample of hospitals.

HCFA has also compiled a comprehensive abstract of the various rate regulation programs that have been authorized under state law to help states compare their own situations with other states.*

But the questions of greatest consequence are: how far can the prospective payment approach be carried and what kind of model program—if any—can be designed?

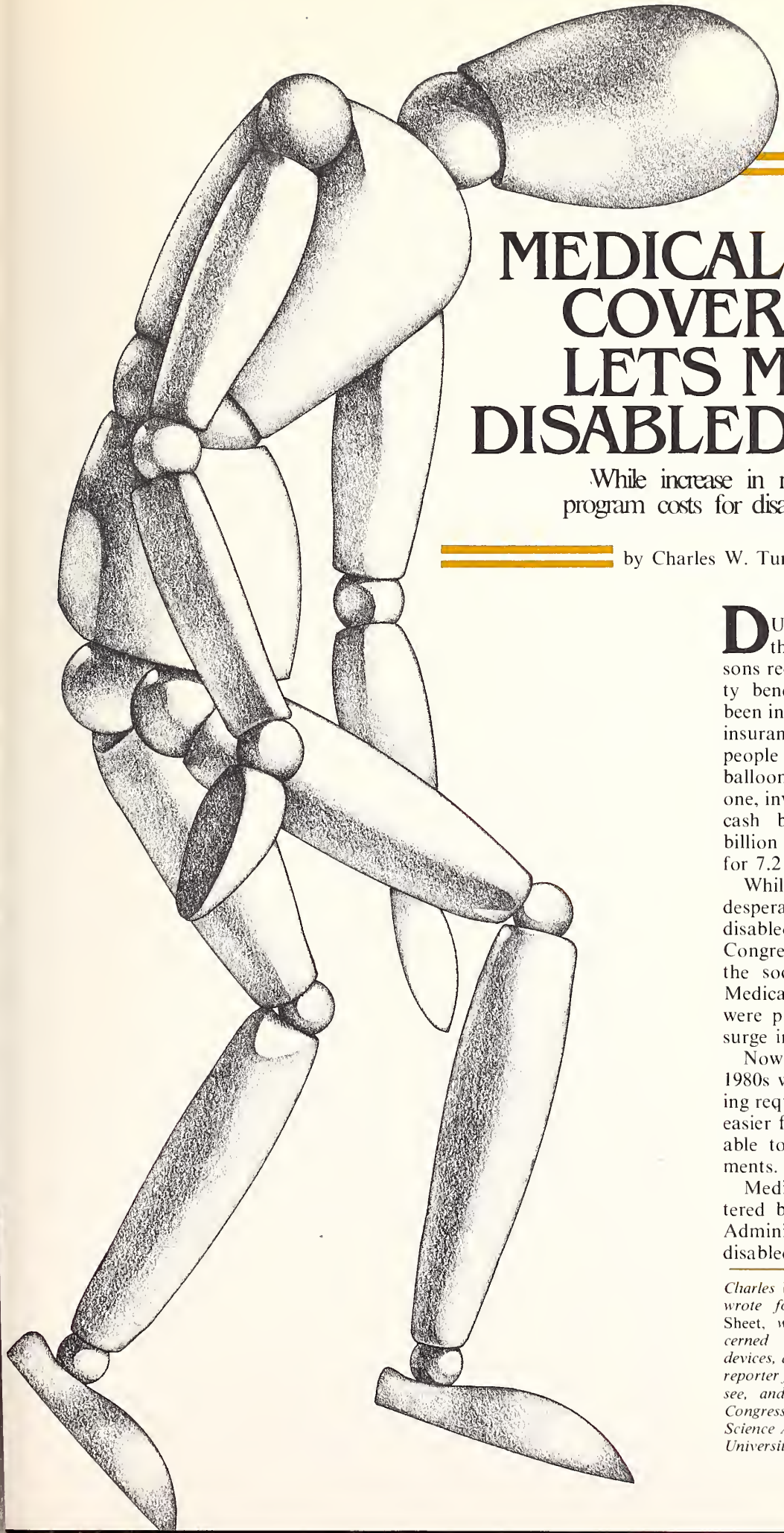
"Right now, there is a very clear relationship between the kind of program that's been adopted, the kind of problems the program was intended to solve, and the political attitude within the state," rate-setting study director Coelen notes. "The issue is the degree to which the mandatory nature of the program is required to bring about eompliance. And that's something we won't know about until we've finished our study."

Some critics of rate regulation believe that restrictions on payments must be made hand-in-hand with changes in demand through such approaches as more competition in health insurance, more use of health maintenance organizations, better use of health education and promotion, experiments in capitation payments to hospitals, more competitive contracting for hospital services, and other ways to lower either the actual volume of hospital services or their cost of production.

The idea is that changing the demand for health services through rate regulation is fine—as long as efficiencies in the supply of services are part of the strategy. "Any supply-side solution will eventually fail, if it isn't coupled with concomitant demand-side solutions," one industry official commented.

Even those disenchanged with rate setting concede that efforts must continue to discover the factors that make it work—and that features that cause excessive and unnecessary friction must be dropped. An effective state-level program that can successfully restrain government spending on health care, yet be responsive to industry interests, is a worthy goal. In today's economic climate, all sides have a stake in improving the state-of-the-art. ■

* HCFA, *Abstracts of State-Legislated Hospital Cost Containment Programs*, to be published soon.



MEDICAL CARE COVERAGE LETS MANY DISABLED WORK

While increase in rolls slows, program costs for disabled still rise

by Charles W. Turbyville

DURING THE DECADE OF the 1970s, the number of persons receiving social security disability benefits doubled—and what had been in 1970 a relatively modest social insurance program helping 3.7 million people at a cost of $4 billion a year ballooned into a significantly costly one, involving by 1979 $17.9 billion in cash benefits and upwards of $8 billion in medical care expenditures for 7.2 million people.

While the programs have provided desperately needed help to many disabled and their families, neither the Congress nor the administrators of the social security system and the Medicare and Medicaid programs were prepared for the unanticipated surge in enrollment and costs.

Now, uncertain as to what the 1980s will bring, Congress is tightening requirements, while making things easier for those beneficiaries who are able to work despite severe impairments.

Medicare and Medicaid (administered by the Health Care Financing Administration) are involved with the disabled through two other federal

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programs, operated by the Social Security Administration (SSA) and the 50 states. These are Disability Insurance, which covers workers and their families who are insured under the social security system, and Supplemental Security Income (SSI), a federal income maintenance program for the aged and blind, as well as the disabled. Workers receiving Disability Insurance benefits and individuals receiving disabled widow's, disabled widower's, or childhood disability benefits are automatically eligible for Medicare coverage after a 24-month waiting period. SSI recipients are immediately eligible for Medicaid benefits.

In practice, one person may receive benefits from all four programs. For example: A worker who qualifies for disability insurance and has a history of low earnings, will receive a correspondingly low Disability Insurance payment, which may make him eligible for the SSI program. Both Medicare and Medicaid then come into play.

Why the increase in rolls?

In a report issued in 1977, SSA actuaries attempted to explain the reasons for the great increase in programs costs in the 1970s. In their judgement, there were five principal causes:

- "Part of the recent increase . . . is due to the rapid rise in benefit levels since 1970, particularly when measured in terms of predisability earnings. From December 1969 to December 1975 there were general benefit increases amounting to 82 percent. Effective in 1973, Medicare benefits became available . . . Benefits this high became an incentive to file a claim for disability benefits, and to pursue the claim through the appellate procedures."

- When unemployment increased after 1970, many physically impaired workers lost their jobs and as a consequence filed for benefits. These persons would not have done so during times of economic expansion when jobs were plentiful.

- "It is possible that the impaired of today do not feel the same social pressure to remain productive as did their counterparts as recently as the late 1960s." The actuaries quoted an expert in the field: ". . .The problem is not simply one of medical diagnosis. The will to work, the economic climate and the 'rehabilitation environment' outweigh the medical condition or problem in many, if not in most, cases."

- The SSA was faced at one and the same time with an increase in yearly disability claims from 700,000 to 1.2 million, 800,00 claims under the "black lung" program, and the beginning of the SSI program with its 1 million disability claims. "All of this put tremendous pressure on the disability adjudicators to move claims quickly."

- People working in the disability program know it is intended to help people, and they know equally well that any one decision has an insignificant effect on overall cost. In close cases, there is a tendency to find in favor of the claimant. "This tendency is likely to result in a small amount of growth in disability incidence rates each year, such as experienced under the DI program prior to 1970, but it can become highly significant during long periods of difficult national economic conditions."

Another contributing factor may be the great expansion in legal services available to lower income persons in the 1970s. More than 40 percent of disability claimants are represented by attorneys. The system works in such a way that there is little to lose by pursuing appeals of decisions taken inside the system. SSA administrative law judges reverse nearly half the claim denials appealed to them, and U.S. district judges reverse more than half the denials that are appealed to *them*. The administrative law judges, incidentally, make up one of the largest judicial systems in the world. There are 600 of them, which is more than all the federal district and appeals judges in the nation.

Medicaid makes the difference

Medicare and Medicaid have come to play a vital role in the lives of the disabled and their families. For many, the medical care they make possible is even more important than the cash benefits. Quite simply, this is because, for the disabled, a cash income sufficient to pay ordinary living costs may be much easier to obtain than health insurance that will even begin to cover their special needs.

Take the circumstances of "Mr. X," a quadraplegic. His case was reported in Congressional testimony by a Wisconsin rehabilitation facility.

Mr. X works in an office, where he earns $8,000 a year. He retained his Medicaid benefits as the result of favorable action taken on his appeal to the state. "The decision was made that Mr. X's employment is 'temporary' because it is renewed from year to year," according to the Wisconsin facility. "The temporary nature of his employment justified entitlement to Medicaid."

"The Medicaid program plays an important role in enabling Mr. X to work and live in the community," a spokesman for the rehabilitation facility said. "Without Medicaid, he might be helplessly confined to an institution or a nursing home without being able to make the constructive contribution to society he makes through his employment."

Documentation of that statement is provided by a list of the benefits Mr. X received from Medicaid, all without any premiums, deductibles or co-payments from him:

- All costs of travel necessary for medical purposes;

- Maintenance of his wheelchair, including a new battery every six months at a cost of $75, new tires each year at $100, new brake forks three or four times a year at $11 each time, and other repairs and parts for the wheels and chair frame as they arise. (When Mr. X's wheelchair, originally bought by the state vocational rehabilitation agency for $4,410, wears out, Medicaid will pay to replace it.);

- Maintenance medication costing $75 a month.

- Physical therapy costing $25 per session. Mr. X's physician recommends two sessions a week.

• A hand splint that enables Mr. X to write. He is ordering a new one; the old one cost $829 and requires about $50 a year for repairs and maintenance.

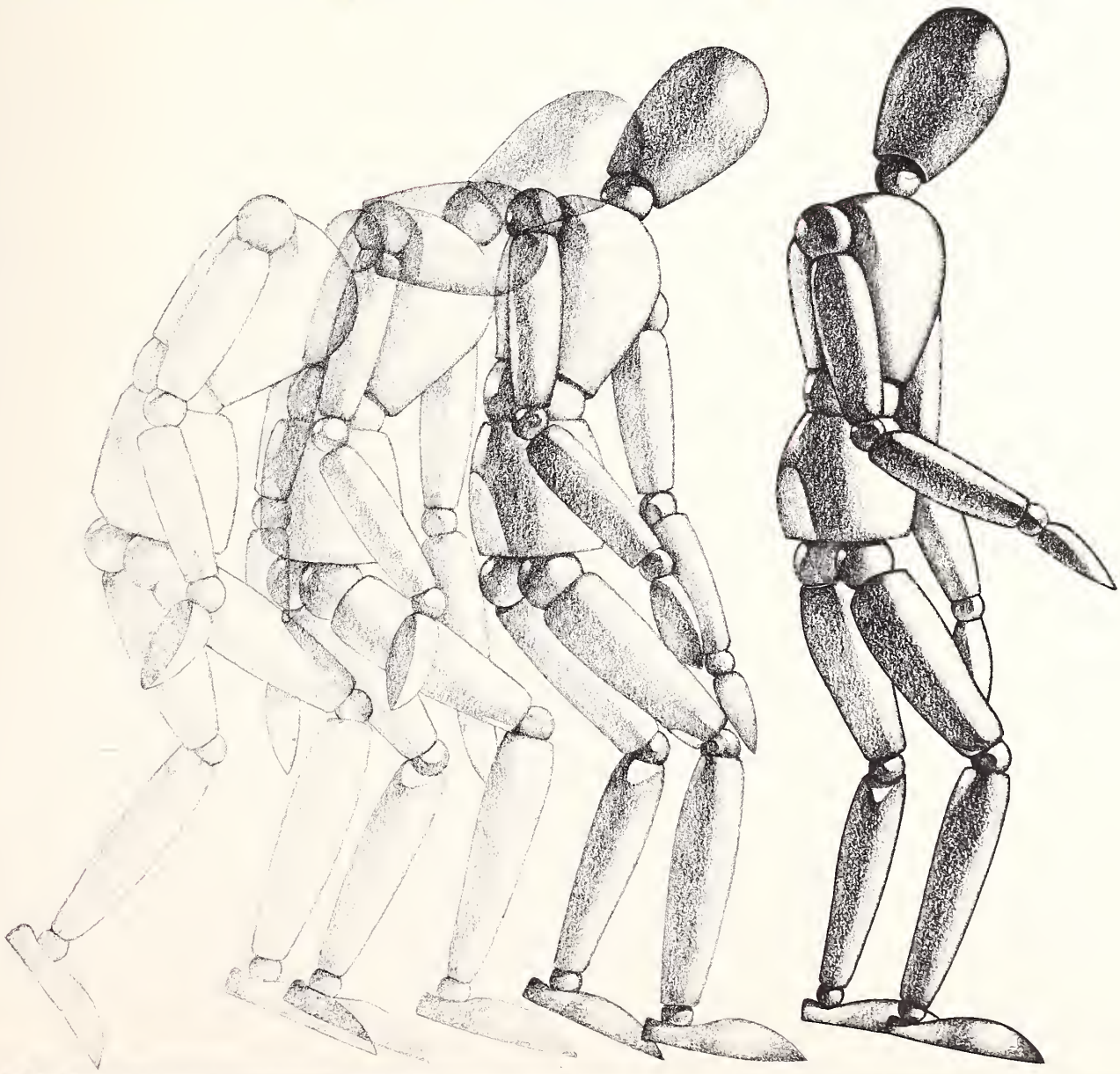
• All of Mr. X's other medical and surgical needs—a gall bladder operation six years ago, for example.

If Mr. X did not have this protection, the alternatives are no less expensive for the government. Deprived of his Medicaid benefits, his earnings could not cover his costs of medical care, as well as other necessary expenses. He would be virtually forced to cease his attempts at self-support and seek the Disability Insurance cash payment and Medicare benefits his earnings history and medical condition would justify. If his DI cash benefit were low, he could well be entitled to SSI payments as well as Medicaid. (If Medicaid did not cover these impairment-related work expenses and Mr. X paid for them, they would be deducted from his earnings when determining his allowable income.)

Mr. X might be considered a fortunate disability beneficiary. Others who want to work must calculate their earnings to a hair lest they find themselves suddenly ineligible for all benefits. Until last year, a disabled person who, after a nine-month "trial work" period, continued to engage in "substantial gainful activity," would be deemed not disabled. Most disabled and people who work closely with them agree that loss of the cash benefit was not nearly so threatening as the loss of Medicare or Medicaid eligibility. One especially sharp fear was the knowledge that, if the disability recurred, the disabled person would have to go through another 24-month waiting period before recovering his Medicare benefits.

Disabled encouraged to work

While these benefits are of critical importance to Mr. X and other disabled beneficiaries, the quadrupling of the cost of the programs caused great concern to the Administration and to the Congress. Since 1965, SSA had administered (in conjunction with state vocational rehabilitation agencies) a rehabilitation program to help as many DI beneficiaries as possible return to productive activity. But obviously further measures were needed.



To reduce the alarming rate of increase in costs, both incentives and disincentives are now being tried. Legislative and administrative actions have been taken to, variously: provide incentives for beneficiaries to become partly or wholly self-supporting; make it harder to get on the rolls in the first place (or, once on, harder to stay on); and cut benefits to the disabled.

In 1980, Congress removed some of the work disincentives faced by the disabled by making the following changes in the programs:

- For persons whose DI coverage ended because they engaged in "substantial gainful activity" (in 1980, this meant earning more than $300 a month) after a trial work period, Medicare entitlement is continued for 24 months. For 15 months after the trial work period ends, benefits can be paid for any month the individual cannot work because of the disability, without reapplication. Also (as previously), payment will still be made for the month disability ceases and two months following.

Deprived of Medicaid, quadraplegic's earnings could not cover his medical care and other expenses.

- Additional impairment-related work expenses (for wheelchairs, other medical devices and equipment, attendant care, drugs, etc.) can be deducted from the disabled beneficiary's earnings, when determining whether he or she can perform substantial gainful activity. Previously, such expenses could be deducted, but only if they were for items needed solely to enable the person to work, and not for daily living.

- For low-income disabled covered by the SSI program and Medicaid, a "demonstration" program was enacted. Persons engaged in "substantial gainful activity" may be considered special beneficiaries and continue to receive cash payments as well as Medicaid. When the person's income rises to the point at which the cash payments phase out, this special beneficiary status ends and so do his Medicaid benefits. However, Congress will provide $18 million over the next three years to pay states 75 percent of the cost of continuing those benefits. To receive the money, the state must determine that the absence of the benefits would impair the disabled person's ability to keep on working and that the person's earnings are too low to provide the benefits for himself.

- Disability insurance beneficiaries who leave the program by making the transition to work will not have to endure a second 24-month waiting period for Medicare benefits, if they again become disabled. The protection lasts for five years (seven for disabled widows and widowers or adults who became disabled before the age of 22). In addition, persons leaving the program before completing the first—and now only—24-month waiting period, can count the months they did wait toward the 24-month requirement if they become disabled again. This protection also lasts for five or seven years.

Rehabilitation: It pays

It is too early to determine the effect of these recent changes in the disability program. But it does appear that SSA's basic program for beneficiary rehabilitation has paid its way. According to a recent analysis* of 1975 data, the savings to the DI trust fund ranged from between $1.39 and $2.72 per dollar spent on DI beneficiaries who had completed their vocational rehabilitation service period. For these beneficiaries, SSA analysts concluded that expenditures for rehabilitation services would be fully "repaid" within 10 years after closing the cases. (The proportion of participants in the rehabilitation program who have completed it and left DI rolls has increased from fiscal years 1975 to 1979, rising from 5.2 percent to 8.3 percent.)

* McManus, Leo A. "Evaluation of Disability Insurance Savings Due to Beneficiary Rehabilitation, *Social Security Bulletin*, February 1981, v. 44 no. 2, p. 19.

In the past few years, however, many more disability cases have been terminated by death than by medical recovery or return to work. In 1977, for example, 139,400 disability insurance beneficiaries died, while only 60,000 recovered. Probably many fewer succeeded in keeping employment over a long period, an earlier SSA report to Congress had indicated.

This is not surprising, given the characteristics of persons receiving Disability Insurance benefits. From the outset of the program in the mid-1950s, it has not been easy to qualify. A disability is defined as "any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months."

The impairment must render the person "unable to engage in any substantial gainful activity" and must be "of such severity that he is not only unable to do his previous work but cannot, considering his age, education, and work experience, engage in any other kind of substantial gainful work which exists in the national economy, regardless of whether such work exists in the immediate area in which he lives, or whether a specific job vacancy exists for him, or whether he would be hired if he applied for work."

Some argue that this impressively daunting requirement has not always been applied administratively, especially during the 1970s. There is evidence that younger, relatively healthier persons have begun to make up a larger proportion of the beneficiaries.

Degenerative disease typifies disabled

Be that as it may, SSA data show that half the disability insurance recipients added to the rolls in 1975 were suffering either from circulatory disease, cancer or mental disorders. Nearly a fifth had diseases of the musculoskeletal system, of which arthritis is the most prominent.

Other categories included conditions resulting from accidents, poisonings, and violence, 5.4 percent; lung

Celebrating International Year of Disabled Persons

The General Assembly of the United Nations proclaimed 1981 as the International Year of Disabled Persons (IYDP) in an effort to encourage the rehabilitation of approximately 400 million people on earth who suffer from some form of physical or mental impairment.

Objectives of the General Assembly for IYDP include: helping disabled persons adjust to society, promoting efforts to provide the disabled with assistance and training for suitable work, educating the public on disabled persons' rights, and encouraging projects to facilitate the practical participation of disabled persons in daily life.

The official IYDP logo represents two people holding hands in solidarity and support of each other in a position of equality.

disease, 6.6 percent; diseases of the nervous system and sense organs, 6.8 percent; endocrine, nutritional and metabolic diseases, 4 percent; and digestive diseases, 3 percent.

SSI beneficiaries fell into a similar pattern, except that 13 percent of them were mentally retarded. A third fewer had circulatory disease, and half as many had cancer.

A witness at 1979 Congressional hearings, Merton C. Bernstein, a professor of law at Washington University in St. Louis, Missouri, summed up the situation as follows:

"Social Security Administration studies show that typically the disabled are: elderly persons who performed unskilled or low skilled labor demanding physical effort which yielded low pay; for the most part, they have had little education. And most suffer from degenerative, not traumatic, conditions."

Congress cuts benefits

Bernstein and other witnesses who spoke in similar terms were protesting—vainly, as it turned out—the other half of the 1980 disability amendments. This was a reduction in Disability Insurance program benefits, particularly for younger workers and for families of disabled breadwinners.

The case for the reductions was summed up for one Congressional subcommittee by Robert J. Myers, a former chief actuary of the Social Security Administration:

"Certainly, we want to provide disability protection for people who are really disabled, who cannot work, but there is a border area of people who can possible work, even though they have a medical impairment" he said. "If the benefits paid to them are too high, obviously they will not have as much incentive to work."

"In fact, under some circumstances, if a benefit plan pays more to a person when he is on the disability roll than when he was previously working, this will have effectively hindered rehabilitation."

Evidence gathered to support the benefit reductions did show that the net incomes of some families and individuals actually improved after the award of disability benefits. This was not because the benefits themselves were so large, but because they were usually not the only source of income. Such tings as food stamps, a spouse's employment, Medicare and Medicaid, exemption of the benefits from federal and state income and payroll tax, and the absence of work expenses may make the beneficiary better off economically than before.

Long-term outlook: Uncertain

What is the net effect of all these actions on the public coffers? Congress's reduction of benefits will save money for the Disability Insurance Trust Fund, which, until three years ago, was on the verge of running out of money. Its income from payroll taxes under the then-current tax rate was being rapidly overtaken by its payments to beneficiaries. But the various extensions of Medicaid and Medicare protection will cost money.

The Congressional Budget Office estimated the net effect on Medicare as an increase of around $130 million a year by 1984, an almost trivial sum when compared to the size and projected cost increases of the Medicare program as a whole. Indeed, even if the disabled population remains relatively stable—the rate of increase has been declining somewhat in the last three years—inflationary increases in Medicare and Medicaid payments on their behalf will be several times that amount.

In 1978-79, applications for benefits were down, awards down even more.

Few experts can be found who will make predictions for the 1980s. This is understandable in light of the failure to predict or explain either the surge in disability beneficiaries in the 1970s or a decline in the disability incidence rate noticed at the end of that decade.

In 1978 and 1979, applications for benefits were down, and awards were down even more. Cutting off of benefits after reviews of cases was up sharply, having nearly doubled since 1975.

There are still more persons getting on the rolls than are getting off, but taken together the trends suggest a leveling off.

"Experts in the field of disability are reluctant to draw many conclusions from these statistics," the staff of the Senate Finance Committee reported last year. "There is a feeling of unease about their significance, particularly over the long term."

The decline in the disability incidence rate in the later 1970s "was not anticipated and its causes are not very clear, so it is uncertain whether the trend will continue in the future," conceded the trustees of the Social Security trust fund in 1979.

Who is disabled? Standards tighten

Clearly one thing that did happen in those years: the administration of the programs tightened up. The initial determination of who is disabled is made by a state agency, usually a state vocational rehabilitation agency. In the last few years, the Social Security Administration has made a major

effort to install quality control systems and write clearer, more specific guidelines.

Some major changes in application approval rates have been brought about by seemingly minor technical adjustments. For example, the term "slightly impairment" has been more clearly defined through federal policy instructions, training sessions, and cases returned to the states after quality assurance review. No one with a "slight impairment" (for example, blindness in one eye or a colostomy) can be eligible for disability benefits—in fact, such a finding cuts off the proceedings almost at the beginning. Since this emphasis on "slight impairment" began, the staff of the House Social Security Subcommittee reported, the number of cases denied on the ground increased from 8 percent in 1975 to 32 percent in 1977 to 36 percent in the last half of 1978.

Similarly, the subcommittee staff found that the elimination in 1976 of the need to show "medical improvement" before a case could be terminated resulted in more terminations. This was because previously some administrators had felt the requirements meant they had to keep people on the benefit rolls who should not have been there in the first place.

Can society continue to maintain the "safety net" protections it now provides the disabled?

The staff of the Senate Finance Committee concluded the experiences of the late 1970s "tend to confirm the crucial importance of administrative factors in the disability programs, and the sensitivity of the disability rolls to what might appear to be technical changes in requirements."

Economic pressures felt in programs

By acting as gatekeepers for medical care, Medicare and Medicaid have become central to the Federal Government's system of support for the disabled. It is difficult to imagine anyone with more to lose if denied access to these two facilitators of care; the difference to the disabled man or woman is often between life as a member of the community and near-total isolation.

Whether the society can continue to maintain the same array of "safety net" protections it now provides for the disabled is a question that will be posed with increasing urgency in the 1980s. In the last three years, Congress has acted twice to reduce the growth in expenditures for the disabled. Now the new Administration is asking for further restraints.

President Ronald Reagan's program for economic recovery, made public February 18th, contains three proposals affecting the Disability Insurance program. The first is administrative: "Under the direction of this Administration, the Social Security Administration will begin to intensively review cases to ensure that only the truly disabled receive benefits." The Administration said that SSA studies "confirm that huge sums are paid to individuals misclassified as disabled."

The second and third steps will require legislation. A so-called "megacap" would be placed on DI benefits to make sure the disabled person's income from all sources "never exceeds the worker's prior earnings, adjusted for inflation." The legislation would also require the disabled to show "a more recent attachment to the workforce."

Adoption of these steps would reduce payments to the disabled from the disability trust fund by $3 million by 1986, according to the Administration. No estimate of the effect on Medicare was provided, but if there are fewer DI beneficiaries, obviously Medicare will spend less for their medical care. (There would however, be more disabled persons receiving the lower SSI disability payment who would be entitled to Medicaid.)

The Administration's plans are directed to restraining program growth—there is no thought of undoing the advances of the 1970s, despite new pressures of inflation and economic lag. Time will tell whether more cutbacks will be required. □

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